EXAMINING URBAN POVERTY, INEQUALITIES AND HUMAN CAPABILITY DEVELOPMENT IN THE CONTEXT OF ADJUSTMENT: THE CASE OF VINGUNGUTI AND BUGURUNI SETTLEMENTS, DAR-ES-SALAAM

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A THESIS SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY IN DEVELOPMENT STUDIES OF THE OPEN UNIVERSITY OF TANZANIA

2013

CERTIFICATION

I, the undersigned, do hereby certify that I have read this thesis, and I recommend to the Higher Degrees Committee this thesis titled **'***Examining Urban Poverty, Inequalities and Human Capability Development In The Context of Adjustment: The Case of Vingunguti and Buguruni Settlements, Dar-es-Salaam'* submitted by Christopher Awinia-Mushi in fulfillment of the requirements for the degree of Doctor of Philosophy.

.....

Dr. Juma Kiduanga (Ph.D)

.....

Date

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DECLARATION

I, **Christopher Awinia-Mushi**, declare that this thesis is entirely a result of my own work except where acknowledged in the text. To the best of my knowledge the work in this thesis has not been submitted to any other University for similar study or any other degree award.

……..

Christopher Awinia-Mushi

……..

Date

DEDICATION

To

My beloved late Father

Agricultural Scientist

AWINIA ABEL MUSHI

B.Sc. Hons (East Africa); PGD Agric. Econ. (Rome)

whose sudden and untimely death in the morning hours of 21st April, 2008

reinvigorated my drive to complete this Thesis, and

To

my sons

TIMOTHY and CHRISTOPHER Jr

as an inspiration to continually strive for excellence

ACKNOWLEDGEMENTS

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Special thanks go to my family including my dear wife Patricia and my sons Timothy and Christopher Junior for their love and support extended to me throughout the course of this study. I would especially like to remember my late

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ABSTRACT

This study on "Examining Urban Poverty, Inequalities and Human Capability Development in the Context of Adjustment: The Case of Vingunguti and Buguruni Settlements, Dar-es-salaam" has investigated the association between three interrelated variables, namely human capability development levels in relation to urban housing and health conditions. It demonstrates how the three variables are associated in determining urban poverty levels. The study used the human capability approach to describe/explain how access to key capabilities enable individuals to function in ways that could improve their quality of life. This includes improving housing and health conditions. A background to the problem of the study led to isolation of social inequalities in housing and health conditions among households as key variables associated with urban poverty in the context of Tanzania and other Least Developed Countries. Empirical findings of the study showed there was positive correlation between low human capability development levels and poverty in housing and health conditions among households. Levels of education attained, access to participation in the urban informal sector, access to credit, assets and vocational skills and levels of income were main factors found to influence effectiveness of households to improve their housing and health conditions. The study recommends the need for urban policy planning and poverty reduction strategies, most notably MKUKUTA II and successor strategies to factor-in social inequalities and human capabilities analysis. It further recommends effective adoption of key measures to develop, repair and sustain human capabilities. The measures recommended include access to participation in the urban informal sector, credit services to the urban poor, upgrading skills through vocational training.

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LIST OF ABBREVIATIONS

AMMP	Adult Morbidity and Mortality Project
CIUP	Community Infrastructure Upgrading Programme
DCC	Dar-es-Salaam City Commission
DHS	Demographic and Health Survey
EOCD	Organisation for Economic Cooperation and Development
FIG	Fédération Internationale des Géomètres (International Federation of Surveyors)
GDP	Gross Domestic Product
HBS	Household Budget Survey
IMC	Ilala Municipal Council
ITNs	Insecticide Treated Nets
LDCs	Least Developed Countries
LGSP	Local Government Support Programme
MDGs	Millennium Development Goals
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini
MKURABITA	Mpango wa Kurasimisha Raslimali na Biashara za Wanyonge Tanzania
MoFEA	Ministry of Finance and Economic Affairs
MoHSW	Ministry of Health and Social Welfare
NBS	National Bureau of Statistics
NGOs	Non-Governmental Organisations
NSGRP	National Strategy for Growth and Reduction of Poverty
OPM	Oxford Policy Management

PEDP	Primary Education Development Programme
PHDR	Poverty and Human Development Report
PPP	Public-Private-Partnerships
PRS	Poverty Reduction Strategy
PRSP	Poverty Reduction Strategy Paper
REPOA	Policy Research for Development
SACCOS	Savings And Credit Co-Operative Society
SEDP	Secondary Education Development Programme
SELF	Small Enterpreneurs Loan Facility
SIDO	Small Industries Development Organisation
SME	Small and Medium Enterprises
UCB	University Consulting Bureau
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Food and Population
UNHABITAT	United Nations Human Settlements Programme
UNICEF	United Nations Children Fund
UPE	Universal Primary Education
URIs	Upper Respiratory Infections
URT	United Republic of Tanzania
USA	United States of America
USD	United States Dollars
WEO	Ward Executive Officer
WHO	World Health Organisation

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background to the Problem

Whereas Tanzania's urban population grew by 2.4 percent in 1948, it rapidly increased by 6.0 percent between 1948 and 1967, to 14 percent between 1967 and 1978, 21 percent between 1978 and 1988, 24 percent between 1988 and 1996, 28 percent between 1996 and 1998, and 41.8 percent between 1998 and 2002 (Lugalla, 1995 (a); Kironde, 2001(a); World Bank, 2001(a). Despite the above-mentioned increases in Tanzania's urban population growth rates, the urban population grew at a much faster rate compared to the overall national population growth rate which grew at an average of only 2.8 percent and 2.9 percent between the inter-census years of 1978 and 1982, and 1988 and 2002, and 2.6 percent between 2002 and 2012 respectively (Osoro, 1988; Lugalla, 1995 (a); Kironde 2001(b); DHS, 2005; NBS, 2004; UN Population Division, 2007; DHS, 2010; www.nbs.go.tz, 2013, NBS and OCGS, 2013). This data shows urban population growth rate in Tanzania grew between 10 and 20 times more than the average national population growth rate. This has inevitably created a demographic situation where the population of Tanzania is increasingly urbanizing.

These developments are consistent with urbanization trends in other developing countries. In 1950, only 15 percent of the African population was living in town or cities compared to 17 percent in Asia and 41 percent in Latin America. By the year 2000, 38 percent of the population in Africa lived in urban areas. This is compared to

37 percent of Asia's population and 75 percent of Latin America's population. In absolute terms, Africa's urban population grew from 32 million in 1950 to 102 million in 1975, and to 295 million in 2000 (United Nations, 2002; Cohen, 2004; UNHABITAT, 2010). A concern that prompted this study was the need to interrogate the quality of the urbanization process in terms of human capability development.

1.1.1 Urbanization and Urban Poverty

The study was prompted to find-out if evolving trends would not cause some unanticipated urban social problems, and if so, how to address it. Arguably, it is an established fact by many authors e.g. Kyessi and Kyessi (2007) that the marginal increase in the urban population is not consistent with the marginal increase in urban economic welfare growth, then it can be anticipated that there will be new social and economic problems that will be triggered by these new urbanisation trends (Lugalla, 1995 (b); UNHABITAT, 2010). This concern relates to what UNHABITAT (2003) and Kyessi and Kyessi (2007) called "urbanization in the face of poverty" and "urbanization under poverty" respectively. These factors are primarily concerned with the ongoing unsustainable mushromming of urban informal settlements (Kalwani, 2001; Mwamfupe, 2005).

The reason why the foregoing authors associated urbanization and poverty is the fact that rapid urban population growth in Tanzania and other Least Developed Countries (LDCs) is mainly driven by rural to urban migration (Ngware and Kironde, 1996; Kalwani, 2001). Rural to urban migration is itself triggered by push factors associated with the stagnation of the rural agriculture sector (Lugalla, 1995 (a); NBS,

2001; UNHABITAT, 2003; NBS, 2009). The primary reason behind these push factors was stagnation of the rural agricultural sector. This stagnation was a result of its primary reliance on cultivation of rain-fed primary export cash crops whose real prices declined as a result of adjustment measures (URT, 2009(a); URT, 2011).

The history of implementation of structural adjustment programmes (SAPs) in Tanzania started back in the 1980s. This period followed the economic crisis and negative trade balances created by a number of internal and external factors (Brilinsky, 1997). The same author states two internal factors that contributed to Tanzania's economic crisis of the 1980s. The first was the ujamaa villagisation programme. Although this programme led to increase in access to social services, it also led to disruption of agricultural patters and caused decline in agricultural output. This disrupted agricultural systems and led to stagnation of the national economy in the mid-1980s. Internal factors were the war with Amin and a rise in the global oil price (Hammond, 1999). At the time of the crisis, the state dominated the economic sector. The state provided nearly universal free social services. The economy was centrally planned with dominance of state-owned enterprises. Agriculture was heavily subsidized. All these factors continue to lay heavy stress on the cash-trapped economy (Tibaijuka, 1998).

In-order to address the economic crisis, Tanzania entered into a series of structural adjustment programmes under the supervision of Bretton Woods Institutions (The International Monetary Fund and The World Bank). In 1986, Tanzania signed a Stand-by Agreement with the IMF and quickly followed by an Economic Recovery Programme (ERP) with World Bank. The following successive structural adjustment

programmes followed. Both the programmes deepened economic reforms. These were the Structural Adjustment Facility (1987), Enhanced Structural Adjustment Facility (1991) and Enhanced Structural Adjustment Facility II (1996) (Hammond, 1999).

Both of the foregoing Structural Adjustment programmes had the following common features. Inflation and debt rise, rising agricultural input prices, falling producer prices, inadequate financing of agricultural financial services, declining credit availability, uneven production gains, and falling productivity. Others were a marketing crisis of products from local industries due to competition from imports arising from liberalization of the economy (Brilinsky, 1997; Hammond, 1999).

These measures led to various shocks to both rural and urban households. Effects such as rise in food inflation, decline in social services, massive layout and retrenchment due to export decline and completion of imports due to de-regulation of the markets. This led to increase urban poverty, inequalities and hardship (Ngware and Kironde, 1996). The structural adjustment measures also led to decline in the meant per capita growth rate in agriculture had been lagging behind the overall national Gross Domestic Product (GDP) rate (Hammond, 1999).

The foregoing is evidenced by NBS (2009); URT (2009(b)) who show although the overall GDP growth rate for Tanzania declined from 7.4 percent growth rate in 2008 to 5 percent in 2009 and 4.2 percent in 2010, primarily due to the afore-mentioned adjustment measures and accelerated the global financial crisis. The combined GDP

growth rate for agriculture was, for example, only 2.7 percent over the same period. URT (2009(a); RAWG, 2012) show the share of agriculture, forest, hunting and fishing sector to the national GDP in Tanzania declined by 18 percent between 1992 and 2001. More recently, URT NBS (2011) shows annual GDP growth rate for agriculture decline by 4.7 percentage points between 2000 and 2009 (URT, 2009: 4-5; URT NBS, 2011).

1.1.2 Rural to Urban Migration

The foregoing inequalities between per capita income in agriculture and non-agricultural sectors were the main factors that contributed to trigger/push factors behind urbanization trends through increased rural to urban migration (Ngware and Kironde, 1996; World bank, 2007; RAWG, 2012). As a result, Ngware and Kironde (1996) state rural to urban migration accounted for settlement of 100,000-300,000 people to Dar-es-Salaam a year (Ngware and Kironde, 1996: 118). Other factors that accounted for rapid urban population growth rates in Tanzania were natural increase from natural reproduction rates (Kalwani, 2001; UNHABITAT, 2003; DHS, 2010; UNHABITAT, 2010). The birth rate of Dar-es-Salaam, for example, was reported to be as high as 4.5 percent per annum between 1988 and 2002 (NBS, 2004; Kabede and Nicholls, 2011). Combined, these factors were responsible for higher concentration of the urban poor in urban informal settlement areas. This is because the new, poor, urban migrants, typically ended-up living in urban informal settlements. Their poor socio-economic status was the primary reason why the informal settlements were characterized by low human capability levels and closely

associated with poor housing and health conditions (Halla, 1999; UNHABITAT, 2003; DCC, 2007).

As a result, Tanzania's urban areas, urban poverty increased faster in new, unplanned and urban informal settlements than in other parts of Dar-es-Salaam and other urban areas. UNHABITAT (2003; 2009) underscore the point that this trend was driven by the migrants to the city and other urban areas who found-it easier to establish themselves in informal settlements in peri-urban areas In many cases, and since most of them were motivated to migrate into these areas by rural poverty, new urban residents tended to have low human capability levels and were income poor (Lugalla, 1995(a); Halla, 1999; Kiduanga, 2002). As a result, peri-urban informal settlements soon end-up being characterized by increasing numbers of poor housing conditions, poor health conditions and low levels of human capability development among its residents (UNHABITAT, 2003, DCC, 2009).

As a result, the general characteristics of urban informal settlements denote poor housing and health conditions. UNHABITAT (2003) outlines these conditions as lack of basic services, substandard housing and illegal and inadequate structures, overcrowding and high density, unhealthy living conditions and hazardous locations, insecure tenure, irregular of informal settlements, minimum settlement size and poverty and social exclusion (UNHABITAT, 2010).

1.1.3 National Strategies to Address Urban Poverty

The foregoing data on urban incqualities shows there was a very small shift in the share of consumption expenditure of the poor in Dar-es-salaam over the last decade

of implementing the Poverty Reduction Strategy (PRS), Mkakati wa Kukuza Uchumi na Kupunguza Umaskini (MKUKUTA I) and MKUKUTA II (from 7.0 percent in 2000/01 to 7.3 percent in 2007).[1] The interest of the study on the MKUKUTA is to evaluate the national approach towards conceptualization and strategies to address urban poverty. The study evaluates its deficiencies in addressing poverty as a capability deprivation and therefore their ability to address capabilities of the urban poor to cope with adjustments. The study pays particularly attention to its focus on social inequalities in human capability development level as a strategy to improve urban housing and health in poor urban informal settlements.

Tanzania has implemented three poverty reduction strategies that cover a period that span from 2000/2001-2014/15. The first strategy was called the PRS that covered financial years 2000/2001 to 2004/2005. The second was known as the MKUKUTA I which covered financial years 2005/06 to 2009/10 (URT, 2000; URT, 2005). The MKUKUTA I was reviewed in financial year 2009/10 and a successor strategy known as MKUKUTA II was formulated and started to be implemented in financial year 2011/12. The MKUKUTA I was reviewed because it is a medium-term macro-economic and poverty reduction policy framework, which lasted in its implementation for a period of three financial years. When three financial years lapsed, it had to be reviewed through broad based national consultations.

[1] MKUKUTA is Swahili acronym for National Strategy for Growth and Reduction of Poverty (NSGRP)

URT (2002), Kyessi and Kyessi (2007), Gould and Ojanen (2003), URT (2007), DCC (2009) conducted their own review of the way the two national poverty reduction strategies namely PRS and MKUKUTA I had impacted on reduction of urban poverty. They found-out the attention accorded to urban poverty had generally increased from the PRS to the MKUKUTA II. The evaluations claim the PRS did not have an explicit focus on urban poverty (URT, 2000; URT, 2001; Kyessi and Lerisse, 2002; URT, 2005). This was primarily because when the PRS was being drafted, there was little available data and policy attention on the extent, nature, and social and economic problems related to urban poverty in Tanzania. A statement was however made in the PRS that the Government of Tanzania would conduct a baseline survey on urban poverty in-order to develop the country's urban poverty profile (URT, 2000).

A baseline survey on urban poverty was conducted and documented by RAWG (2002). Key features of urban poverty that were noted were increase in the number of people without salaried employment, increase in rural to urban migration leading to growth of the informal sector, stagnation of growth of the private sector in the urban informal economy, low formal training skills among the labour force, lack of capital and business premises among petty traders, and limited access to land and housing including dwelling in urban informal settlements. Others were overcrowding in rooms of residence, the presence of hazardous work activities such as sand mining and quarrying, increasing number of child labour and street children (RAWG, 2002). All these factors point-out to low levels of human capability development.

Some, but not all of the issues that were identified by the 2002 urban poverty baseline were taken-up by MKUKUTA I and MKUKUTA II. MKUKUTA I response to urban poverty was mainly confined to addressing the problem of rising unplanned urban settlements, and the strain it creates on municipal Government's capacity to provide adequate social services. These included a focus on housing and health services to low income households, the urban unemployed, vulnerable groups and those in the informal sector (URT, 2005: 7-8). A response to this was implementation of national programmes namely the Community Infrastructure Upgrading Programme (CIUP), strategic cities programmes, MKURABITA, as well as creation of a Government fund to survey 20,000 plots in Dar-es-Salaam (DCC, 2002, URT-MKURABITA, 2008; CIUP, 2010; UN-HABITAT – Cities Alliance, 2010). An urban initiative that was started under MKUKUTA I and carried-over to MKUKUTA II included developing a new rapid transport system for Dar-es-Salaam (URT-PMO, 2010).

MKUKUTA II was more silent in its approach to urban poverty. It only mentioned decent shelter and human settlement as a response to urban poverty, confining itself largely to scaling-up town planning, surveys, issuance of land titles, regularisation of unplanned settlements and enforcement of urban land-use plans (URT, 2010: 79-81). Other urban interventions of MKUKUTA II include land-surveying to improve basic urban community facilities and services and containment of urban vulnerability arising from human settlements in hazard prone lands such as steep slopes, flood plains, river valleys, dump-sites causing poor housing and environment health

conditions. Others are creation of Central Business districts such as Kigamboni satellite city, Mchikichini and Magomeni business parks (URT, 2010: 17).

While recognizing increased attention was given to infrastructure poverty (Kyessi and Kyessi (2002), lack of attention to social inequalities in human capabilities developments was a key gap that remained across all the three poverty reduction strategies (Gould, J and Ojanen, 2003; URT, 2010). The reason behind this was the three poverty strategies continued to rely on aggregate data for cities and other Tanzania urban areas as a whole, which, due to high social inequality levels, obscured underling deprivations among the lowest income quintiles urban social groups. In many cases, these were the human capability deprived urban poor (Kyessi, 2002; UN-HABITAT, 2010). This practice created lack of sufficient policy attention to the seriousness of the extent and depth of urban poverty in certain, mostly peri-urban parts of cities, towns and townships in Tanzania. They did not pay sufficient attention to social inequalities in human capabilities which are created by "divided cities" which are typical to urbanisation under low human capability conditions (Kyessi, 2002). Under such conditions, some human capability developed city residents grow proportionate to the urban economy, which is usually above national average. However others remain stagnant, and even marginalized and impoverished by adjustment measures. The more recent Tanzania Five Year Development Plan is even more silent to issues to human capacity development as a basis for growth and poverty reduction. Its strategy on human capital development is limited to expansion of formal tertiary and higher learning development and formalisation of land ownership so they can be used as loan collateral (URT, 2011:50, 68-70).

The interest of the study on the MKUKUTA is to evaluate the national approach towards conceptualization and strategies to address urban poverty. The study evaluates its deficiencies in addressing poverty as a capability deprivation and therefore their ability to address capabilities of the urban poor to cope with adjustments. The study pays particularly attention to its focus on social inequalities in human capability development level as a strategy to improve urban housing and health in poor urban informal settlements.

1.1.4 Urbanization and Social Inequalities

Urban poverty in Dar-es-Salaam was characterized by social inequalities in housing conditions and settlement services such as access roads, water and sewage infrastructure and in their ability to transform the skills and assets they have to income that can be used to reduce their housing and health problems (RAWG, 2002; DCC, 2009). This capacity to identify and engage a main economic activity and to transform it to address main problems is what is meant by human capability development (Robeyns, 2005; Nondo and Coetzee, 2002). This being said, there were some urban residents in urban informal settlements who were able to improve their housing conditions and general wellbeing in dimension of health conditions while capability deprived households in the same area were in long-term poverty (Lerisse and Kyessi, 2002; UNHABITAT, 2010). This shows the problem of urban poverty was not just a problem of geographical location or informality in development of settlements of peri-urban areas. It was also a manifestation of geographically distributed inequalities in human capability development levels (Lerisse and Kyessi, 2002; UNHABITAT, 2010). These social inequalities were a

main determinant for long-term poverty among the capability deprived urban poor. Intra-urban social inequalities, including inequalities in human capability development levels within unplanned informal settlements themselves, played a big role to determined a segment of the urban poor who remained under long-term poverty (Lerisse and Kyessi, 2002; NBS, 2009; UNHABITAT, 2010).

The foregoing was evidenced by a decomposition of available income data which revealed inter-city social inequalities played an important factor in urban poverty. The poorest expenditure quintile (i.e. 20 percent) of Dar-es-Salaam city residents, for example, accounted for only 7.3 percent of the total consumption expenditure in 2007, while the richest quintile accounted for almost half, 41.4 percent (NBS, 2009). These social inequalities were a long-term trend as evidenced by consumption expenditure of the poorest 20 percent in Dar-es-Salaam only rose by 0.3 7.0 percent in a decade (NBS and OPM, 2002; NBS, 2009; URT, 2009).

High social inequality levels in Tanzania's urban areas were a vivid and real problem. Mchomvu (1996) reported the gini-coefficient for Tanzania at various periods indicated social inequalities increased between the adjustment years of 1983 and 1991, and that between 1993 and 1995 the situation started to worsen even further (Mchomvu, 1996:14). Likwelile (2001) and NBS (2002) point-out that the level of social inequalities in Dar es Salaam continued to increase from a gini-coefficient level of 0.30 to 0.36 between 1991/92 and 2000/01. NBS (2002) found levels of inequalities to be highest in Dar es Salaam and lowest in rural areas, and that inequalities had generally increased over the last decade, particularly in Dar es Salaam (NBS, 2002). NBS (2009) showed the levels of inequalities in Tanzania's

urban areas had persisted to the post-adjustment era. The same source showed social inequalities were highest in other urban areas at a gini coefficient of 0.35 closely followed by a gini coefficient of 0.34 for Dar-es-Salaam compared to a gini coefficient of 0.33 for rural areas (NBS, 2009). The same source showed, overall, inequality worsened in Dar-es-Salaam between 1991/92 and 2007, but was highest in other urban areas (NBS, 2009). A more recent survey on levels of social inequalities in Dar es Salaam done by URT (2009) revealed that, despite registered levels in economic growth in Dar-es-Salaam, there was very little changes in the share of total consumption and expenditure for the bottom two (poorest) expenditure quintiles between 1991 and 2007. A further evidence to deteriorating effects of social inequalities is Dar-es-Salaam was provided by URT (2002). URT (2002) found social inequalities in urban areas in Tanzania was manifested by concentration of poor and vulnerable population groups in urban informal settlements, typically characterized by households with low levels of human capabilities development, poor housing and health conditions among households (URT, 2002; 2004). All of the above point towards the importance of paying attention to the long-term urban poor in Dar-es-Salaam and other urban areas of Tanzania.

It is these long-term urban poor who remain in great peril of worsening urban poverty conditions, and who development policy and national poverty reduction strategies such as the PRS, MKUKUTA I and MKUKUTA II continue to fail to identify and target their needs. The long-term urban poor are the ones that were affected most by the effects of adjustment measures under conditions of low human capability development levels.

As a result, adjustment measures contributed to increased social inequalities in human capability development levels and urban poverty in dimensions of housing and health conditions. They were also the most hurt by increased and long-term inequalities (Lugalla, 1995 (b); Halla, 1999; Kiduanga, 2002).

The case-study area of Buguruni and Vingunguti wards are in the epicentre of rapid, unsustainable, unplanned urbanization, with a large number of rural to urban migrants settling in the area haphazardly. As a result, there is proliferation of informal properties, inaccessible and unserviced housing, dominance of the informal economy under low levels of human capability development, and poor urban infrastructure to service households in the area. This translates to what has been termed as “urbanization in the face of poverty” as characterized by poor average incomes and low capabilities to improve housing and health conditions among households of the case-study areas of Buguruni and Vingunguti areas (Kyessi, 2002).

1.2 Statement of the Problem

The analysis derived from the background to the problems has shown urban population growth is rising in dramatic exponential rates, leading to urban poverty and social inequalities. The capacity of municipal authorities to cope with rising population demands and adjustments is limited, thus leading to development of urban informal settlements. As such, urban poverty in Tanzania is expressly manifested in social inequalities in human capability development of the urban poor to improve housing conditions, which is immediately manifested in social inequalities in human capability development to improve health conditions among households. This study

seeks to understand why human capability development that was intended to be built among households in the case-study area of Buguruni and Vingunguti wards was not achieved, despite its importance to reducing urban poverty, social inequalities and improving health conditions among households.

1.3 Main Objective

To investigate the dynamics of urban human capability development as adjustment measures for reduction of poverty and inequalities in dimensions of housing between the poor and non-poor households in Buguruni and Vingunguti wards.

1.3.1 Specific Objectives

The specific objectives of this study were to:

(a) To Explore the level of human capability of households in informal settlements

(b) To examine the main factor that affect households to attain human capability elements

(c) To find-out the extent to which households' human capability development have impact on poverty reduction and health status inequalities

(d) To explore the effectiveness of the human capability of households in reducing housing and health status

1.3.2 Research Questions

The research questions for this study are:

What were the main types of economic activities of households in the case-study?

1. What main factors affect households in the case-study area to attain main human capability elements?
2. To what extent did human capability elements attained by households reduce their main housing and health problems?
3. What social inequalities in human capability development existed in the case-study areas and how did these affect social inequalities in human capabilities, housing and health conditions within and between the case-study areas?

The foregoing are the core research questions. However there are additional filter research questions which followed the above-mentioned core research questions. These questions have been outlined in the field survey questionnaire which is attached as Appendix 1 of this thesis.

1.4 Significance of the Study

The study is significance for two reasons. First, it raises the importance of social inequalities in addressing urban poverty. Given high inequalities levels in urban areas, urban poverty tends to be geographically distributed and confined to urban informal settlements. The study will investigate the nature of these inequalities and their inter-rellationship to human capability development levels to improve housing and health conditions. The findings and recommendations of the study will provide evidence that targeted strategies to address urban poverty in urban informal areas is needed, using a human capability approach.

Second, it provides a basis to address sustainable urbanization. Once this is achieved, it will assist a multitude of rural to urban migrants to integrate into the urban

economy and reduce urban poverty. This will be achieved through investing in human capabilities and enlarging opportunities through increasing access to credit, vocational skills, productive assets and basic services. It will in-turn contribute to urban employment, welfare and poverty reduction.

Third, the background to the study revealed social inequalities, poor housing and health conditions are what define urban poverty. In its worst form, urban poverty is manifested in slums. The study will contribute to knowledge leading to containment of slums. The approach entails investing in human capabilities of the urban poor so they can function in different ways to improve urban informal settlements by improving their housing conditions.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Review of Empirical Literature

This chapter provides a review of empirical literature on urban poverty experiences from different regions of the world in sub-Saharan Africa (SSA), Africa region as a whole, other developing countries in Asia and Latin America, as well as current of former urbanization trends in Europe and North America. The review of empirical literature covers a wide range of thematic issues including urbanization trends in SSA, developing countries and globally. Literature review on urbanization in Tanzania has been extensively covered in the section on background to the problem. However the literature review Chapter will also reflect and link literature on the experience of Tanzania to other urbanization experiences being presented as part of the literature review the review of literature will also cover topics such as urbanization and human capabilities development, health and urbanization, and social inequalities between the urban poor and non-poor.

The Chapter also presents the theoretical framework used for the study. This section is accompanied by presentation of the conceptual framework and knowledge gap that was used as an entry point for this study. Limitations of the theoretical framework are also provided.

2.1.1 Definition of Key Concepts

This section provides a definition of the key concepts of this study. The key concepts include poverty, adjustment measures, human capabilities and social inequalities.

2.1.1.1 Poverty

Poverty, irrespective whether it is rural or urban, is defined as a shortfall in the absolute minimum human needs that are needed for maintaining a minimum living standard and/or lead a decent human life (URT NBS, 2005; URT HBS, 2009; URT NGSRP II, 2010; http://www.tanzania.go.tz/poverty.html). Poverty is defined in absolute terms. In the context of Tanzania, headcount poverty is used to specify the proportion of people who live below a specified poverty line. The poverty-line is constructed from calculating household expenditure as a proxy of income. This is then evaluating against the purchasing power of households to buy and consume food and basic needs. Households which fall below the food poverty-line are called absolute poor. Households which fall below the basic needs poverty line are referred to as basic needs poor (Bagachwa, 1994; NBS, 2009; RAG, 2012).

2.1.1.2 Adjustment Measures

Adjustment measures refer to cyclic changes in key macro-economic parameters. Although not conclusive, these parameters include fiscal and monetary policies as well as the overall macro-economic framework of an economy (Greene, 2001). In many cases, adjustment requires changes in macro-economic policies. The changes aim at correcting market distortions created by human (e.g. social and economic policies) and non-human (e.g. climate change, disasters, wars) factors.

Adjustment measures are used by this study to refer to micro-economic and welfare implications of adjustment measures. Normally, macro-economic adjustment have micro-economic implications. These include social effects of measures such as food price, unemployment rates, and export liberalization. In the context of Tanzania, the

latter has accounted for disruption of social services and closing down of parastatal organizations (Tibaijuka, 1998). This was found to cause cyclic shocks in household consumption and consequent cyclic risks, shocks and vulnerabilities to households. In this context, the term adjustment measures should not be confused with structural adjustment programmes (SAPs). The latter are programmes used by the Bretton Woods Institutions (IMF and World Bank) to achieve macro-economic stabilization.

2.1.1.3 Human Capabilities

Human capabilities are defined as the ability of a person to perform or not to be able to perform a range of functions (Sen 1999; 2003; Murugan (2003). Sen (1992) defines human capability development as a set of vectors of functionings which reflect a person's freedom to lead one life over another. According to the capability approach, poverty is not conceptualized as lack of income or lack of access to consumption of certain utilities alone, but poverty is defined as deprivation in basic capabilities needed to function in ways to be able to achieve sufficient household the income in-order to be able to command consumption of basic needs (Clark, 2010).

The concept on entitlement is therefore central to the human capability approach. An entitlement is defined as a guarantee of access to benefits based on established rights, legislation or policy instruments (Sen, 1999; http://en.wikipedia.org/wiki/ Entitlement). Entitlements are further defined as certain set of commodities, endowments or provisions that a person has access to and/or commands. Examples of entitlements are access to good levels of education, health, credit services and productive assets (Clark, 2010).

2.1.1.4 Social Inequalities

Economic inequality (or "wealth and income differences") comprises all disparities in the distribution of economic assets and income. The term typically refers to inequality among individuals and groups within a society. Social inequality refers to a situation in which individuals in a society do not have equal social status. Areas of potential social inequality include the extent of property rights and access to education, health care and other social goods (Rawls, 1971; Coates *et al*, 1977).

2.1.2 Urbanisation Trends in Sub-Saharan Africa, Developing Countries and Globally

Bocquier (2005) has calculated the proportion of the world population living in cities and towns in the year 2030 would be roughly 50 percent of the global population. UN (2005) has estimated this proportion could rise up-to 60 percent. In any case, and more importantly, is that both sources predict for the first time, the majority of the world's population will be living in urban areas. In terms of the actual numbers of the global population that resides in urban areas, UN (2005) reports the global proportion of the urban population has risen dramatically from 13 percent (220 million) in 1900, to 29 percent (732 million) in 1950, to 49 percent (3.2 billion) in 2005. Thus, the urbanization pace for the world as a whole is experiencing a quantum growth.

Whereas by 1960 it had taken 10,000 years for the population living in urban areas to reach 1 billion, the next billion was added within only 25 years. It is estimated that it will take only 15 years to increase from 3 to 4 billion urban population by 2018

(Satterthwaste, 2007; www.londoninternational.ac.uk/2004). It is therefore observed that global urban population is rising both in actual numbers, and also proportionally to the population that resides in rural areas, as well as in the rate of growth of both the actual numbers and as a proportion of the rural population.

NBS (2011) acknowledges this as the trend in Tanzania. The proportion of urban population in Tanzania increased from 13.3 percent in 1978 to 17.9 percent and 22.6 percent in 1988 and 2002 respectively (NBS, 2011: 21). This signifies an increase of 9.3 percentage points between 1978 and 2002. The foregoing information attests to the fact that urbanization is an irreversible process (FIG, 2010: 21).

As a result of the foregoing, the world has in the last 50 years alone witnessed the emergence of more megacities (i.e. cities with population greater than 10 million) than ever before (Lugalla, 1995 (b); UNHABITAT, 2010; NBS, 2011). Forbes and Lindfield (1997), FIG (2010), UNHABITAT (2010) report the number of megacities have increased from 2 in 1950 to 20 in 2005; with 17 megacities being in less developed countries (FIG, 2010). It is projected that there will be 26 megacities in 2015, 22 of them being in less developed regions. 18 out of these will be in Asia alone. It is estimated that by 2015, more than 10 percent of the world's population will live in these megacities compared to just 1.7 percent in 1950 (Piorr et al, 2010). United Nations reports that these high population growth areas are likely to be worse in smaller and poorer countries like Tanzania (United Nations, 1994; UNFPA, 2003; Satterthwaite, 2005). UN (2007) estimates, for example, that 93 percent of global urban growth will occur in developing nations with 80 percent of urban growth

occurring in Asia and Africa. If current trends persist, by 2030, the developing world will be more than 50 percent urban (United Nations, 1994; UNFPA, 2003; UNHABITAT, 2003, 2010).

United Nations (1994), UNHABITAT (2007) report global demographic trends reveal the urban population is rapidly increasing in all (LDCs). It further estimates that the world's urban population in LDCs doubled in the past two decades alone (UNHABITAT, 2003, 2010). Whereas in 1950 only 18 percent of people in developing countries lived in urban areas, by the 1990s, more than 25 percent of the population was residing in urban areas. In 2000, the proportion was reported to be 40 percent (UNHABITAT, 2003). Existing demographic trends suggest that this burgeoning urban population in LDCs will not be spread evenly, but it will be highly concentrated in a few large cities. Higher levels of concentration are expected to be in urban informal settlements. Urban informal settlements are characterized by poor housing and health conditions among households, and low levels of human capabilities (Kironde, 2001, UNHABITAT, 2010).

Table 1: Sub-Saharan City Growth to 2025 (in Millions of People)

Variable	**1990**	**2010**	**2025**	**% Change**
Sub-Saharan Africa	527	937	1,362	258
Urban Population	149	387	705	473
Urban population as percentage of the total population	28	41	52	86

Source: Hanson, (2007)

Evidence on the rate of urbanisation in SSA is provided by Hanson (2007). He estimates that by 2025, the number of population that will be residing in urban areas in SSA will be growing at a pace that is twice as the general population as shown by Table 1.

It can be seen from Table 1 above that by the year 2025, the number of the urban population SSA will grow by almost twice the number of total population growth (i.e. by 473 percent between 1990 and 2025 compared to 258 percent for the total population). This trend is confirmed by The Economist (2002), and UNHABITAT (2010) which cite that when overall national population growth rates in developing countries range from 2-3 percent per annum, urban population growth rates tend to average between 4-5 percent.

The foregoing literature shows projections of urban population growth rates in developing countries are high, and thus contribute to fuelling an urban sprawl and urban poverty in dimensions of poor housing conditions, health condition and low levels of human capacity development among poor urban households. It is estimated that over 33 percent of Africa's 1 billion inhabitants currently live in urban areas, but by 2030, it is estimated that proportion will rise to 50 percent (The Economist, 2002). The most populous city in Africa is Cairo, which has a population of 13.5 million people, is expected to grow at 23 percent in the next 15 years. However by 2025, it is estimated that Cairo will be overtaken by other emerging megacities in SSA namely Lagos and Kinshasa. It is estimated that, by that time, the two cities will have a total population of 15.8 million and 15 million inhabitants respectively. Table 2 shows the drastic projected rise of new cities in SSA.

Table 2: City Growth in Sub-Saharan Africa by 2020

Size of Cities	**1990**	**2020**	**% Change**
More than 5 million inhabitants	0	11	
1 to 5 million inhabitants	18	59	536
500,000 to 1 million	26	75	288
100,000 to 500,000	180	585	325
20,000 to 100,000	790	2,200	278
All cities	**1,014**	**2,930**	**289**

Source: Hanson, 2007

Table 2 shows there is drastic growth of cities of different sizes in SSA. It is important to note that there will be a significant increase in cities between 1 million to 5 million inhabitants. This category of cities will increase drastically by 536 percent in only three decades between 1990 and 2020. Cities of up to 5 million inhabitants are by no means small. This is especially taking into cognizance that the population for Dar-es-Salaam in Tanzania was 4,364,541 in 2012 (NBS-OSGS, 2013: 2).

Table 3: National and Urban Population Growth in Selected Developing Countries

Country	**Average annual population growth (%)**			**Average annual rate of urban population growth (%)**			**Population in capital city as % of urban population**	
	1970-80	1980-92	2000-15	1970-80	1980-92	2000-15	1990	2000
Kenya	3.7	3.6	1.5	8.5	7.7	3.5	26	23.2
Egypt	2.1	2.4	1.5	2.5	2.5	2.3	39	34.1
India	2.3	2.1	1.2	3.9	3.1	2.7	4	4.1
Malaysia	2.4	2.5	1.4	5.0	4.8	2.4	22	10.8
Philippines	2.5	2.4	1.6	3.8	3.8	2.6	32	24
Mexico	2.9	2.0	1.2	4.1	2.9	1.6	34	24.7
Brazil	2.4	2.0	1.1	4.1	3.3	1.5	2	1.4
Argentina	1.6	1.3	1.1	2.2	1.7	1.3	41	37.7

Source: UNHABITAT, (2010)

However this is not a conditions that is peculiar to SSA alone. Table 3 presents an analysis of the average national annual population growth compared to their corresponding urban population growth in selected developing countries:

UNHABITAT (2010) underscores the general urban population trends in developing countries across the world have been higher compared to average national population growth rates. UNHABITAT (2010) reports Antananarivo (Madagascar), Johannesburg (South Africa), Cairo (Egypt) and Mexico City (Mexico) grew at 1.5 times faster than the average national population growth in the respective countries. It can further be seen from Table 3 above that although average annual rate of urban population growth rate was projected to slightly decrease between 2000-2015, it was still consistently higher than projected average annual population growth levels in all countries included in the survey.

A proper interpretation of this slight projected urban annual average population growth rates should not be interpreted as urban population is on the decrease. Instead, it should be properly construed as a manifestation of urbanization away from major capital and/or commercial metropolitan megacities. This kind of urban trends confirm data presented by Table 2 above that show the trend towards continued transformation of rural areas into small townships and rural-urban enclaves (Hanson, 2007; Kalwani, 2001). This means urban population growth is not only increasing through internal increase as expressed by higher average annual urban population growth, but also spatial increase through emergence of smaller townships. This is evidenced by findings presented by Table 3.

2.1.3 Urbanisation and Human Capabilities

High levels of urban population growth have been the main reason for spatial expansion of urban areas in developing countries (Freire and Stren 2001). It is also further documented that high rates of urban population growth which are almost double the average national population growth levels is the primary factor that drives unsustainable urbanization in developing countries (World Bank, 2005; FIG, 2010; UNHABITAT, 2010). That, in spite of reported improvements in macro-economic indicators in many countries in the economic South (developing world), this has been a primary reason for increase in the number of urban residents who live in extremely precarious conditions (Simler and Dudwick, 2010). Freire and Stren (2001) argue that this rapid and uncontrolled nature of urbanization creates a situation where there are some urban groups that are being excluded and benefit little from overall economic growth that occurs in cities. This exclusionary and marginalization factor, which is characteristic of urban economies, tends to breed social inequalities. Social inequalities, in-turn, serve as a major contributing factor to human capability deprivations among the urban poor (World Bank, 2005; UNHABITAT, 2010).

Freire and Stren (2001) argue there are increased inequalities being formed in the distribution of human capabilities between skilled and non-skilled workers. The same author further argues that this results into pockets of deep poverty. The existence of these diversities reflect the distribution of low human capabilities (i.e. non-skilled workers) continue to persist in urban areas (Freire and Stren, 2001: 287, UNHABITAT, 2010). This shows the long-term projections of urban poverty reduction and resilience against adjustments in developing countries are gloom.

Immediate attention therefore needs to be given to the economic welfare implications of widespread social inequalities in human capability distribution in urban centres. Omari (1995) provides an explanation on the interrelationship between the urban informal economy and human capabilities to development. He argues that, due to low capability levels, people who migrate to urban areas in search for jobs in the formal sector find themselves "jobless." Omari (1995) sheds more light why they find the informal economy as a first option for urban income activities. He argues the reason is the nature of the informal enterprises where the urban poor thrive.

The character of an informal enterprise is based on its nature of ease of entry; reliance of indigenous technology; family ownership of the enterprise; small scale operations; labour intensive and adapted technology; requires skills acquired outside the formal school system and unregulated markets. In contrast, the same author describes formal enterprises as characterized by difficult of entry; frequent reliance of overseas resources; corporate ownership; large scale operation; capital intensive and often imported technology; formally acquired skills (often needing expatriates) and regulated markets (through tariffs, quarters and trade licenses). They therefore become a safe-lending for young rural to urban migrants with low human capability levels to survive.

2.1.3.1 Human Capabilities and Adjustment Measures

Further understanding is needed on the interrelationship between low levels of human capability development and vulnerabilities of the urban poor to adjustment measures. Adjustment measures in this case include changes that affect income and

livelihoods of the urban poor. These include cyclic economic fluctuations and shocks such as food and non-food inflation, but also short and long-term, environmental, natural and health risks. UNHABITAT (2010) defines urban vulnerable population groups as those that lack capabilities to respond to uncertainties caused by adjustment measures including the on-going global economic crisis (UNHABITAT, 2010).

The foregoing line of thinking is underscored by Beal and Fox (2007) who argue attention needs to be given to two aspects regarding how the urban poor interface with adjustment. The first regards how they respond to shocks or stress arising from the gradual erosion of their capabilities. The second regards how the urban poor can generate sustained levels and/or sustain household income.

The development of these capabilities is found to be an important factor to counter adjustment measures related to cyclic economic fluctuations such as inflation of food and non-food items which lead to dwindling of financial, social, organizational and personal capabilities to cope. World Bank (2005) states that it is a fact that low urban income groups, particularly those in, but not limited to LDCs are undergoing adjustment. The same author continues to argue that, the income groups whose income has worsened most end-up becoming more vulnerable to a wide range of other shocks and stresses related to economic adjustment. World Bank (2005) further argues that expanding human capabilities means investing in basic capabilities such as skills development, access to assets through microfinance and health services to the poor in-order to strengthen them to cope with adjustments.

Human capabilities are contingent on accessing a certain outlay of entitlements. Available evidence from FIG (2010) shows there are recurrent dimensions of urban development challenges being caused by low levels of capabilities and social inequalities based on the level of development of a country in which a city is located. Given high urbanization rates, UNHABITAT (2010) cautions municipal authorities in LDCs cannot mobilize the resources needed to make necessary investments in developing basic capabilities due to low urban economic growth levels. Administrative capabilities provide institutional and structural capabilities which area set-up in ways that facilitate opportunities of the poor to performs functions and achieve valued ends (Sen, 1999). Consequently, low levels of municipal institutional and structural capabilities will create urban challenges which constrain the development of human capabilities among the urban poor. As a result of this, the urban poor are left more vulnerable to adverse effects of adjustment (World Bank, 2005; UNHABITAT, 2010). In Cebu city for example, where 40 percent of urban households did not receive municipal garbage collection services, resulting in waste being dumped in bins, streets and waterways. 35 percent of households burnt their waste while 12 percent deposited waste in open pits.

Moreover, 28 percent of the population in Cebu city was not supplied with clean water and did not have access to sanitary toilets. As a result, water borne diseases comprise the three leading causes of morbidity and second leading cause of infant mortality in the city (Forbes and Lindfield, 1997: 69). Table 4 shows a comparative analysis of problems of urbanization in dimensions of urban housing conditions in different cities of the world.

Table 4: Problems of Urbanization in Different Cities of the World[2]

Problem	Hong Kong	Tokyo	Seoul	Istan-bul	London	New York	Lagos
Informal settlements (land tenure, development approvals, building control)	N	Y	N	Y	N	N	Y/High
Traffic management	Y/Med	Y	Y	Y	Y	N	Y/High
Natural hazards (floods, fires)	N	Y	Y	Y	Y	N	Y/High
Unclear responsibilities and mandates (within or between administrations)	N	N	N	N	N	N	Y/High
Uncoordinated planning	N	N	-	N	N	N	Y/High
Water management (fresh water supply and waste water disposal)	Y/Med	Y	N	Y	N	N	Y/High
Inadequate provision of continuous electrical power	N	Y	N	N	N	N	Y/High
Visual pollution and garbage disposal	Y/Med	Y	N	N	N	Y	Y/High
Air and water pollution control	Y/Med	Y	Y	N	Y	Y	Y/High

Source: FIG (international Federation of Surveyors), (2010)

The urban problems shown by Table 4 shows different types of problems faced by urban areas ranging from low, middle and developed countries. Table 4 shows all cities which were surveyed, irrespective of which region of the world, or level of economic development of the country they are-in, faced one type of urban challenge over another. These challenges include various complex administrative, management, financial and governance challenges in managing and serving housing, settlements, average incomes, and public and environmental health services to the world's rapid urban population growth. In the context of Tanzania, Kalwani (2001) confirms this and reports people in high density squatter areas of Moshi municipality generated 81.4 percent of solid waste compared to 18.6 percent in low and medium density areas. The high percentage in the high density squatter area was mainly a function of population increase (Kalwani, 2001: 19). The normal trend of allocating

[2] Y=Yes
N= No
Med = medium
- = no assessment available

resources and infrastructure however usually runs in the contrary. Allocation of resources are in many cases disproportionately in favour of affluent parts of municipal areas (Lugalla, 1995 (b); UCLAS and DHV, 2004). Both of these problems mentioned in Table 4 above introduce risks and shocks which cause adjustment to poor households in urban informal settlements.

Reflecting diminished municipal capacities, problems such as traffic management, water management, air and water pollution, and natural hazards were almost universal in all the cities. Table 4 further shows there were social inequalities in the extent which cities from countries which were at different levels of economic development were affected by key problems of urbanization (FIG, 2010). East Asian cities of Hong Kong (China) and Tokyo (Japan) were affected by the majority of urban problems which were listed in the case study, while the city of Lagos (Nigeria) was severely affected in all counts. It is interesting to see that Tokyo, despite being a city in an industrialized developed country, was still faced with common problems associated by urbanization.

The problems include formation of informal settlements including lack of land and housing tenure, building development controls, continuous electrical power supply, management of fresh water supply and waste water disposal, air and water pollution, and adequate levels of garbage disposal. The city of New York (United States of America) on the other hand, despite being a city in an industrialized developed country and the world's first megacity, was reported to have problems with management of fresh water supply and waste water disposal, air, water pollution and garbage disposal.

The very reason why Tokyo, Hong Kong and New York cities were affected despite being located in financially strong economies is evidence that cities typically face institutional and governance challenges which make management of cities particularly challenging. New York and Tokyo serve as examples of multi-nucleus megacities which require complex and advanced social and physical infrastructure to serve an increasing high population (FIG, 2010; UNHABITAT, 2010).

The challenges that these cities face show economic growth alone cannot be a factor in making cities more sustainable (Hanson, 2007). It also shows the sheer burden that high population growth cause to a city administrative capacities can make even cities which are located in most advanced economies not to be insulated from problems of urbanization, urban poverty and adjustments. This phenomenon is noted by Mwamfupe (2005) in the context of Tanzania. He argues that as urban areas grow, the demand for plots outpaces the capacity of municipal authorities to survey and supply plots. As a result, urban residents start to take their own initiatives to acquire land. That this has been a major factor contributing to uncontrolled expansion of urban informal settlements in Tanzania.

2.1.4 Urbanisation and its Impact on Urban Health Conditions

UNHABITAT (2010) describes environmental health related diseases typically occur in urban informal settlement and/or squatter and slum areas. These diseases include frequent incidences of disease outbreaks such as malaria, diarrheal and respiratory diseases. These cases typically arise from polluted environment, poor sanitation, unhygienic and unsafe water supply, poor ventilated rooms due to overcrowding, and

poor housing conditions (Savingy, 2004; UCLAS and DHV, 2004; URT-MoHSW, 2006; UNHABITAT, 2010). UNHABITAT (2010) further reports that these environmental health conditions affect many cities of the world. These conditions are more acute in urban informal settlements of cities in the LDCs of different parts of the world.

According to Freire and Stren (2001), health conditions among residents in squatter areas of cities are influenced by inherent inequality trends within cities. These inequalities are found to arise from intra-city biases which cause disproportionate physical and social investments in favour of more affluent parts of cities. According to UNHABITAT (2010), in Delhi in the 1980s,large quantities of sewage originating from affluent parts of the city was directed fertilise and to irrigate areas in the outskirts of the city which were formerly designated as agricultural lands. However, this waste disposal arrangement to the city's outskirts continued despite migration and settlement of residents in the former agricultural lands. Thus, rapid and unplanned spatial urbanization in Delhi resulted into poor urban migrants forming urban informal settlements in former agricultural land. As a result, these areas faced health risks as they settled into the former agricultural lands and dump-sites.

The original rationale for dumping waste disposal in a dump-site in the area was to promote gardening to feed the burgeoning urban population. However UNHABITAT (2010) reports this practice and mind-set of bias against low income urban informal settlements of the city was extended to dumping of hazardous and toxic industrial waste. The area eventually got severely affected by hazardous pollution from

chemical and industrial effluents, sewage contamination, waste disposal, mud slides, and flooding. As a result, resident of the squatter area were faced with high environmental health risks (UNHABITAT, 2010; FIG, 2010:18).

In the same vein, in Calcutta, the combination of two reinforcing developments of urbanization and industrialization contributed to poor health conditions among the population in poor sub-urban areas of the city. The health hazards experienced included causing air pollution, inadequate access to housing services, as well as water pollution from liquid and solid waste that were released from affluent areas on the eastern outskirts of the city (UNHABITAT, 2010; FIG, 2010). Residents of these poor sub-urban areas were also affected by environmental pollution caused by chemicals released from metal, pottery and tannery manufacturing industries (UNHABITAT, 2010). In Hanoi on the other hand, where squatter areas were on the increase, only 45 percent of solid waste disposal was collected in 1987. The remainder was being dissipated along roadways and in waterways by unserviced households, thereby increasing public and environmental health among households (Forbes and Lindfield, 1997).

This position is supported by Moore *et al* (2003), Savingy (2004) who point-out that potential health risks and hazards that presents themselves with rapid urbanization in third world countries include construction of sub-standard housing on marginal lands, overcrowding, increasing levels of air and water pollution and inadequate sanitation services. UNICEF (2003) cautions that human fecal waste is an important source of disease causing organism and probably the most single dangerous pollutant

of surface water supply in peri-urban areas. Moore et al (2003) point-out that human fecal waste collection is a major problem in many cities in LDCs. Inadequate fecal waste collection poses a threat of developing a variety of hazards, in most cases in shantytowns which have been erected rapidly on any available land (Moore at al, 2003: 273). The same authors caution that uncollected solid waste can serve as breeding sites of a variety of vectors of infectious diseases such as flies, mosquitoes, rodents and insects than can be a source of rapid epidemics in these marginal urban informal settlements. URT-MoHSW (2006) alludes to this and presents that Dar-es-Salaam was among regions with the highest malaria case fatality rate in 2004. It had a rate of 4.5 percentage compared to national average of 2.6 percent for Tanzania Mainland. Dar-es-Salaam was also leading in TB cases with a total of 15, 804 cases in 2004 compared to the national average of 3,266 cases per region. The same author further argues that this is indicative of several factors that demonstrate poverty and overburdened public health system in large urban areas.

Besides urban generated public and environmental health conditions, Hugo (2003) reports there are ecological health implications which flow from migration and eventually settlements of rural to urban migrants into informal peri-urban settlements. These health implications arise from the fact that new urban migrant settlers come from different ecological areas with different vectors and disease patterns, and as a result they may not have antibodies to cope with new localized diseases in their new areas of destination. As a result, these disease prone migrants, who often settle in already public and environmentally health hazardous areas, tend to be a source of intermittent disease outbreaks and epidemics (Hugo, 2003). Circular

seasonal migrants in cities like Jakarta, for example, were found to be less resistant to infectious diseases, which, unfortunately, they are forced to be constantly exposed to as a result of sleeping outdoors and consuming cheap contaminated food and water (Hugo, 2003; UNHABITAT, 2010). This shows there is a direct association between deteriorating urban housing conditions, lack of basic community and public health infrastructure and health conditions among households in poor sub-urban areas.

2.1.5 Social Inequalities Between the Urban Poor and Non-Poor

Hugo (2003); UNHABITAT (2007); Simler and Dudwick (2010) show urban population growth creates problems of inequalities in human capability distribution and income and non-income poverty. Although there is a general global trend to this effect, the trend is more acute in LDCs (Simler and Dudwick, 2010; UNHABITAT, 2007; 2010). UNHABITAT (2007) showed this is the case when analyzing gini-coefficients of a sub-set of 26 and 19 cities in Africa and Latin America respectively. The analysis showed the average gini-coefficient in the African cities was 0.54 and Latin American cities was 0.55. Both of these are indicative of sharp income inequalities. Reflective of this, high inequalities between the poor and non-poor were also reported in Tanzania. Social inequalities in Tanzania increased during the adjustment years of 1983 and 1991 with average income of the non-poor to the poor increasing from a ratio of 8.1:1 to 29.6:1 (EOCD 2000). Social inequalities in Dar-es-Salaam increased by 0.6 percentage points between 1991/92 and 2000/01 and by 0.4 percentage points from 1991/92 and 2007 (NBS, 2009).

Inspite of this, the PRS, MKUKUTA I and MKUKUTA II have continue to hold-on the premise that urban areas, as an aggregate entity, are better-off, and are on-track to

reach national poverty reduction targets. The tendency of poverty reduction strategies to ignore urban inequalities was central to the lack of policy attention to the problem of urban poverty in Tanzania. Semboja and Therkildsen (1995) provide an explanation of the adverse economic welfare implications of increased inequalities. They state that even a 0.2 annual increase in the aggregate gini index will eliminate the total effect of growth of mean consumption by 1 percent per year. The same authors state that these deteriorations (in inequality trends) were found to have profound negative impact on household consumption expenditure of the poor which ultimately determined the capability of households to improve their housing and health conditions (Semboja and Therkildsen, 1995; UNHABITAT, 2010). Whereas the share of consumption expenditure of the richest consumption quintile in Dar-es-Salaam had slightly fallen by 1.1 percent from 42.5 in 2000/01 to 41.4 percent in 2007, their share was still seven (07) times more than that of the poorest consumption expenditure (NBS, 2009).

Torres (1993) cautions that ignoring social inequalities in the design of poverty reduction strategies may lead to creation of barriers against broad based and inclusive urban social development, which will, in turn, inhibit the development of human capabilities for the urban poor (Torres, 1993:11; Sen, 1999). More importantly, this caution remains relevant to the ongoing discourse on urban poverty, social inequalities and adjustment measures in Tanzania.

Work done by Simler and Dudwick (2010) showed intra-urban inequality trends are on an increase in a number of case-study African cities. According to them, the gini-coefficients for Kampala and Maputo cities in Uganda and Mozambique respectively

were significantly high and increasing. They note that inequality increased sharply in Maputo from 0.44 in 199/97 to 0.52 in 2002/03 compared to slight corresponding increase of the gini-coefficient from 0.40 to 0.42 respectively for the country as a whole (Simler and Dudwick, 2010: 43). Their work showed cities were more unequal compared to aggregated social inequalities across the country as a whole. High gini-coefficient rates were also found to be the trend in other cities of the developing world such as Johannesburg, Buffalo City and Ekurhuleni of East London in South Africa (which had a gini-coefficient of 0.71); Goiana, Fortaleza, Belo Horizonte and Brasilia in Brazil (0.60); Bogota, Barranquilla and Cali in Colombia; Lagos in Nigeria, Chiagmai and Udonthai in Thailand; Catamarca and Buenos Aires in Argentina; Santiago and Chillan in Chile (0.55); and Quito in Ecuador (0.51). Other cities with high inequality levels were Addis Ababa, Ethiopia; Nairobi, Kenya; Maseru, Lesotho; Mexico City, Mexico; Ho Chi Minh City, Vietnam and Hong Kong, China (0.52) (UNHABITAT, 2010).

The extent of intra-urban social inequalities becomes more apparent as the focus shifts from inequalities in income to inequalities in consumption, especially when it comes to access and consumption of key urban services (Hugo, 2003). Services are important for sustainable urbanization. Equitable, functioning and reliable services contribute to development of basic capabilities, housing conditions and health conditions among households, thus contributing to sustainable urbanization. Table 5 shows there were significant disparities in improved housing conditions in the form of flush toilets between poor and non-poor urban residents in selected sub-Sahara African cities of Accra, Kampala and Maputo.

Table 5: Access to Flush Toilet in Accra, Maputo and Kampala

City (Country)	Quintile of Wealth Index				
	Poorest	2nd	3rd	4th	Richest
Accra (Ghana)	18.7 (00.)	24.5 (0.5)	34.9 (12.0)	63.1 (12.0)	92.6 (55.0)
Kampala (Uganda)	0.7 (0.0)	2.4 (0.0)	2.4 (0.0)	1.4 (0.02)	54.1 (5.82)
Maputo (Mozambique)	0.0 (0.0)	0.0 (0.0)	1.8 (0.0)	12.0 (0.0)	75.6 (14.47)

Source: Simler and Dudwick, 2010 derived from Uganda DHS (2006), Ghana DHS, 2008 and Mozambique DHS, (2003)

It needs to be taken into consideration that social inequalities in access to flush toilets is an indicator of underlying inequalities in human capability development levels, and access to income and basic community infrastructure that services and supports different households and settlements in poor sub-urban areas. Access to a flush toilet is also an indicator of levels of development of the basic social and environmental infrastructure, shelter conditions, and land-use planning that is available to a particular settlement. When 92.6 percent of the richest households in Accra had access to a flush toilet in 2008, for example, only 18.7 percent of the poorest households used flush toilet in the same city. Social inequalities in access to flush toilets were even sharper in Kampala and Maputo cities. Even less proportion of poorer households had access to flush toilets in Kampala compared to Accra.

As Table 5 above shows only 0.7 percent of the poorest households in Kampala had access to a flush toilet compared to 54.1 percent of the richest. In Mozambique, where intra-urban inequalities are sharpest of the three cities, 75.6 percent of richest households had access to a flush toilet while the poorest, second and third wealth quintiles had no flush toilets at all. None of the three bottom wealth quintiles of the

three cities had at least half of their households having access to flush toilets. Accra was the only city that had its fourth (second-richest) wealth quintile only slightly passing the 50 percent mark of its households that had access to a flush toilet. Lagos for example, which is one of the most unequal cities in SSA with a gini-coefficient of 0.64 in 2006, also exhibited high levels of non-income inequalities. 40 percent of Lagos residents lived in overcrowded housing, 25 percent had no access to adequate sanitation and 40 percent of males and 12 percent of females were unemployed (UNHABITAT, 2010).

2.2 Overview of Theoretical Framework

The theoretical framework that underpins this study is the human capability approach. The human capability approach was first comprehensively defined by Armatya Sen (1999). He defined capabilities as the range of freedoms that a person attains, and then makes one able to do or not to do a certain range of things. According to Sen (1999; 2003), Murugan (2003) a person's capability is determined by the ability of the economy to provide a certain range of entitlements. The concept on entitlement is therefore central to the human capability approach. An entitlement is defined as a guarantee of access to benefits based on established rights, legislation or policy instruments (Sen, 1999; http://en.wikipedia.org/wiki/ Entitlement). Entitlements are further defined as certain set of commodities, endowments or provisions that a person has access to and/or commands. Examples of entitlements are access to good levels of education, health, credit services and productive assets (Clark, 2010). This discussion on entitlements becomes particularly relevant in relation to urbanization and capability deprivation in developing countries.

The human capability approach pays special attention to the way non-income factors influence relative capabilities of different social economic groups to function in ways that achieve wellbeing (Sen, 2004; Clark, 2010). These factors include such as social-structural arrangements, relative access to endowments, economic facilities, political freedom, and freedom of movement, association. Others include occupational choice, social inequalities, demographic distribution of skills and physical health and distribution of ownership of assets (Sen, 2004; Clark, 2010). Bourgnignon, Ferreira and Lustig (2005).

An important distinction of the human capability approach as a theoretical framework is that it evaluates poverty by taking into consideration non-income dimensions of wellbeing (Sen, 1999). The capability approach is a departure from traditional economic utilitarian approach which evaluates wellbeing from the stand-point of relative access to income and/or consumption (Clark, 2010). Furthermore, the capability approach pays special attention to the centrality of social inequalities in human development. Bourgnignon, Ferreira and Lustig (2005) draw a link between urban poverty and social inequalities by arguing that disruptions in flow of incomes of urban households translates into immediate disruption in capabilities of its members to survive. The application of this approach to this study offers a contribution to the ongoing scholarly discourse on sustainable urbanization in the 21st centrury.

The human capability approach provides an analytical framework that perceives urban poverty not as a short-fall of consumption. This is a departure from the way

urban poverty has often, consistently and traditionally been depicted by official government statistics, and by extension, the PRS, MKUKUTA I and MKUKUTA II. Instead, the approach views urban poverty as a manifestation of deprivations in the space of capabilities (Sen, 1999). Poverty is not regarded just as income shortfalls below an arbitrary "poverty line (Clark, 2010)." Instead, the latter is regarded as an outcome of capability deprivation and not the other way round (Sen, 2003).

The concept of human capability evolved as an analytical framework to explain the relationship between the way an economy is structured in-order to provide or limit opportunities that allow individuals and households to access different alternative set of utilities (Encyclopedia of Social Sciences, 1978; Sen, 1992, 1999). As such, the human capability approach conceptualizes human development in terms of "capabilities of individual people or collectively as social groups" to attain a certain minimum level of human wellbeing (Sen, 1992). Under the approach, poverty is principally understood as deprivations in capabilities to function in ways to achieve valued-ends, and command basic consumption levels (http://en.wikipedia.org/wiki/ Capability_approach; UNDP, 2003).

The approach emphasises the importance of analyzing not only how human beings actually function to attain wellbeing and/or valued ends that they wish to achieve, but also the range of different alternative functions that they can actually achieve given current levels or incremental levels of endowments and/or entitlements that they can access. These alternative functions or "paths" of development that individuals and households can achieve are simply referred to as "capabilities to function."

The human capability approach is expressed by a simple function known as Sen's Capability Index as follows:

$$E_{1...}E_n = C_{1...}C_n = F_{1...}F_n$$

Where E=entitlements

C=capabilities[3]

F=Functionings

N=population

Source: Sen, (1999)

As it can be seen from Sen's capability formula above, entitlements, which mean access to certain endowments, benefits and goods is an important instrumental step to realisation of capabilities. Under the approach, development means provision of access to entitlements, thus enlarging opportunities, or capabilities, to achieve more functions. Attained capabilities, it-turn, have instrumental value in performing functionings (Sen, 1999).

Based on the analytical framework mentioned above, the focus of economic policy is therefore not to increase household incomes as a measure to stimulate consumption, but to enlarge opportunities of individuals to perform wider range of different alternative functions that they can actually achieve through elimination of inequalities that constrain the poor to access endowments and/or entitlements (Sen, 1999). Endowments in this case include an enabling environment to create

[3] Also sometimes referred by Sen (1999) as *freedoms*

opportunities to enable people to achieve more complex functionings. Examples of these enabling environments are creating conditions such as realization of individual liberties, human and social capital, credit services, vocational skills, social arrangements and culture (Clark, 2010: 2-3). These set of capabilities are collectively referred to as entitlements.

In Tanzania, entitlements of the urban poor are or should principally be provided through national policies such as the PRS, MKUKUTA I and MKUKUTA II. These policy instruments are expected to enshrine and guarantee the provision of entitlements in order to enlarge opportunities of the human capability deprived poor to achieve valued ends. However, lack of attention to urban social inequalities has made the policy instruments to be relatively silent on entitlements to the capability deprived urban poor. As a result, entitlements are disproportionately provided to more affluent parts of cities and denied to the poor in urban informal settlements.

The afore-mentioned capability calculus suggests that if entitlements are not provided and/or accessed, then individuals and households will be fall in the space of capability deprivations, and therefore limited in ways that they cannot achieve valued ends.

2.2.1 Conceptual Framework of the Study

The conceptual framework relates to how the study has conceptualized the theoretical framework in the context of the study. The study has conceptualized human capabilities approach to urban poverty as a relationship between basic

capabilities which unlock complex capabilities. It has been well established for example by Sen (1999; 2004); Alkire and Deneulin (2004) that basic functionings are a necessary step to the achievement of higher and more complex levels of functionings. It is further recognized that individuals and households use elementary capabilities to "transform" them to be able to achieve complex levels of functionings (Tipples, 2009; Clark, 2010). The conceptualization of the study is further informed by Robeyns (2005) who underscores the point that there are three levels that are instrumental in converting basic entitlements such as goods and services into more complex functionings to achieve certain beings and doings. The three levels, (a) personal, (b) social, and (c) environmental conversations factors are presented as follows.

According to Robeyns (2005), **Personal conversion factors** involve personal attributes that contribute to a person's capability to function. These include the ability to command basic functions such as the state of body metabolism, physical condition, ones biological sex (i.e. whether a person is male of female), and ones level of skills and intelligence. It is evident that if a person is disabled or is in a bad physical and health condition, then the person will be limited to perform even the most basic function of mobility. In this case, capability strengthening involves addressing the causes of this limitation. Such a measure can typically be provided through providing access to a certain minimum level of entitlements. Lack of access to food, shelter, disability support and health services can contribute to limitations of individuals to perform personal conversion factors. Guaranteeing the provision of entitlements through the PRS, MKUKUTA I and MKUKUTA II can be one of the

measures to address limitations that cause low personal conversion capabilities and convert them into functionings.

Social conversion factors on the other hand include social arrangements such as public policies, social inequalities and discrimination between the poor and non-poor, discriminatory gender roles, social hierarchies and power relations. If social, structural and economic arrangements make it a norm for individuals from certain parts of a city not to access basic entitlements, then it becomes a basis for capability deprivations.

These entitlements include capabilities such as education, micro-credit services and portable water supply. If the poor in urban informal settlements miss these elements, they fail to exercise social conversion factors. It therefore becomes much more difficult if not impossible for them to use other entitlements/endowments available to them in-order to enable a certain functioning to occur. Lack of social conversion factors among certain households accounts for social inequalities in human capability development.

Environmental conversion factors on the other hand include the effects of spatial and climatic location on human capabilities to convert entitlements into functionings. Environment factors include differences in endowments. These include housing and settlement conditions such as physical characteristics such as access to water, fertile soil, clean environment and paved roads. Lack of access to entitlements such as these makes it very difficult, if not impossible, to use a good or service to enable a certain functioning.

The conceptual framework identified a list of basic capabilities which are instrumental to make people function in ways to achieve valued-ends. The list was derived from Nondo and Coetzee (2002) as follows:

(a) Human capital, including health conditions, skills and level of education attained,

(b) Ownership and access of productive assets such as land, housing, value adding tools, machines and/or equipments,

(c) Social capital as manifested in membership and linkages to reciprocity networks within communities and households as a mechanism for pooling income. This enables access to financial services including credit,

(d) Quality of labour, which forms the most important asset of poor people, and

(e) Access to consumption capabilities, which include household access to and consumption of durable and non-durable assets, and consumable in whatever combination.

Deducing from the foregoing, the conceptual framework to identify and conceptualise the building blocks for capability development. These include focusing on Robeyns (2005)'s "conversion factors" including physical, social and environment as follows.

The foregoing conceptual framework elaborates how the study has used the human capability development framework to approach the study. The framework shows reduction of urban poverty and adverse effects of adjustments starts by addressing the basic capabilities of the poor.

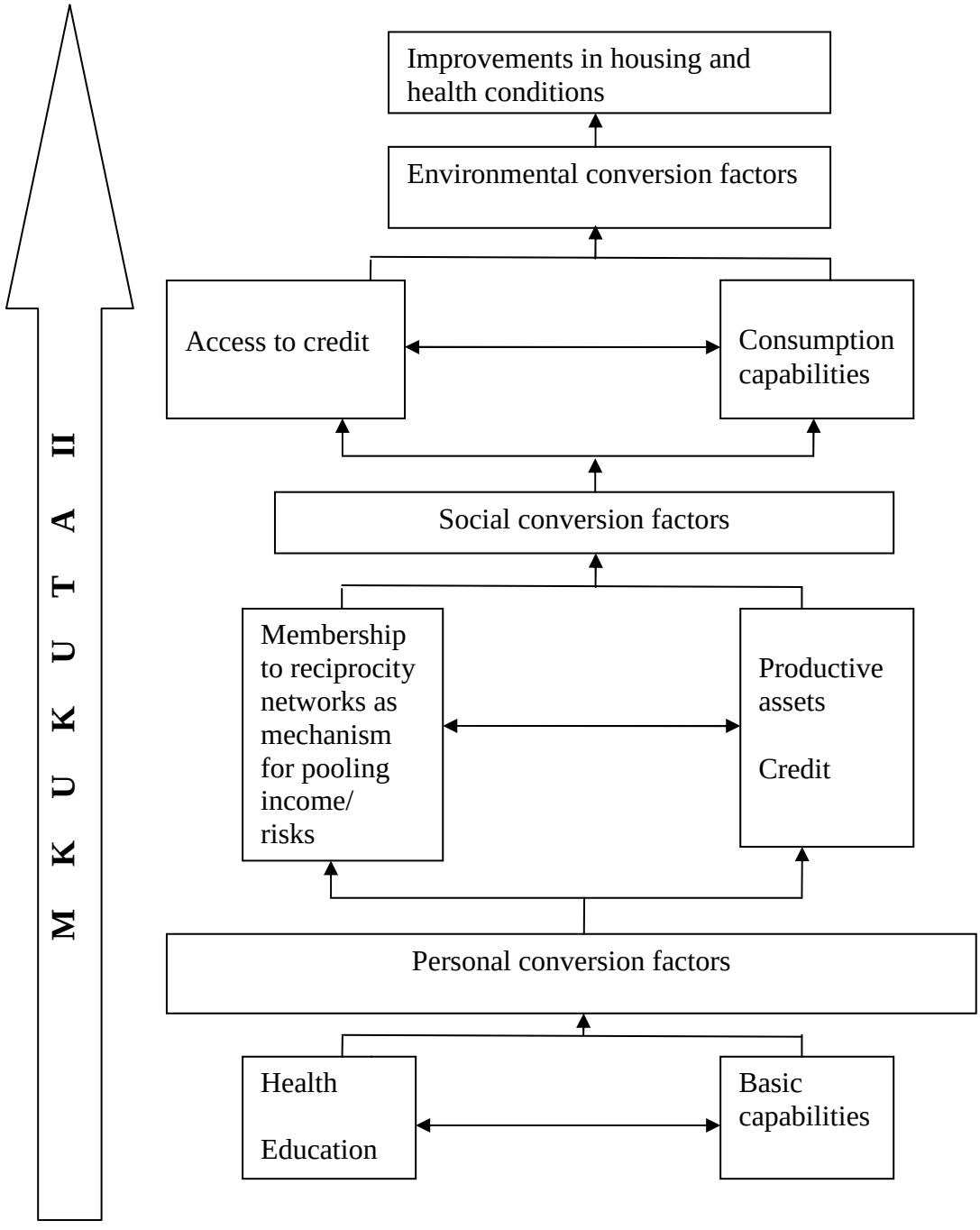


Figure 1: Conceptual Framework for Addressing Urban Poverty through Human Capabilities Development

This enables people to achieve the function of personal conversion factors, to reach valued-ends. Once people start to function in this way, they begin to integrate in social networks. These include the informal sector market place, credit associations and access business service organizations. In the process, they begin to develop capabilities to function in more complex ways. In the process the urban poor begin to acquire productive assets. These productive assets enable the function of environmental conversion factors. This in-turn enables them to function in ways that improve the quality of labour. It also affords them the opportunity to enlarge prospects of increasing their consumption capabilities. These in-turn are translated into capabilities of the urban poor to improve their housing and health conditions. The conceptual framework lays emphasis for the MKUKUTA to focus on developing capabilities of the poor at all levels in-order to enable both personal, social and environment conversion factors.

2.2.2 Limitations of the Theoretical Framework

This study would like to note at this juncture that the capability approach is not without limitations. Its key limitations are outlined below.

2.2.2.1 Evaluates Policy by Ends Paying Less Importance to Means

One of the first known limitations of the capability approach is that it mainly evaluates policies according to their impact on people's capabilities (Clark, 2010). As a result of this, between the means and ends to wellbeing and development, the approach disproportionately attaches importance to the ends of wellbeing. According to Clark (2010), in practice, this should not be the case in all situations.

There are some cases where some means are simultaneously also ends or are an important component to the eventual realization of an end (Clark, 2010). Taking for example, the capability of being in good health is an end in itself. However it is also a means to other ends such as capability to work, and therefore capability to earn income. The ability to earn an income is a means to an end of improving one's housing condition. One of the limitations of the capability approach is it does not take development as a cumulative process which depends on certain ends as prior conditions which can serve as means to attain higher ends.

Likewise other ends are also means to achieve more complex functions. These include access to clean water, doctors and medical care, protection from infections and diseases, knowledge of health issues, whether people are nourished or not, high quality education and political participation. All these are ends which also serve as means to other more complex ends.

In-order to overcome this limitation, the evaluation of policies from a human capability development perspective should also take into account the accumulation of means as interim ends in themselves. A policy implication of this would be evaluate the cumulative stock of achieved ends and match them together to determine which ends area also means to achieve other, higher ends.

In-order to mitigate this limitation, there is a need to make exceptions where it makes more sense to investigate people's achieved functionings directly instead of just evaluating the capabilities. There is therefore the need for evaluations of the wellbeing to also focus on actual results that capabilities have been able to achieve

"along the way." It is the measurement of these functionings that will provide information related to what has actually been achieved, and how individuals made choices to exercise their freedom to achieve a given path of alternative functionings. An evaluation of the means followed becomes particularly important in determining cases where choice is complicated by social, economic and structural uncertainties which limits a person to exercise their capabilities in a rational way. Adjustment measures and high social economic inequalities are examples of structural issues which can prevent people to function in ways that exercise their capabilities to achieve valued ends. In certain cases, evaluations should be able to take stock of actual achieved functionings, which are the doing and beings of individuals such as the level of being healthy, well nourished, safe and having good housing conditions.

2.2.1.2 Assumption that Valued-ends are Synonymous with Wellbeing

The second limitation of the capability approach is that it assumes valued ends are compatible with economic wellbeing. The approach does not take into consideration that, in practice, the definition of "valued ends" can be open to different interpretation according to one's culture, social background and motives. Robeyns (2005) states that in real life, a person's idea of "a good life" are significantly influenced by one's family, tribal, religious, community and cultural ties and background (Robeyns, 2005: 101-102).

A case in point can be instances where individuals use their human capability levels to attain incomes but use the incomes to purchase illicit drugs, for example. Taken strictly, the capability approach can interpret illicit drugs, in this case, as "valued

ends" to an individual, but it contributes to diminished long-term health of the individual. Indeed, in the long-term, this “freedom of the individual” to perform the function of purchasing and consuming illicit drugs can lead to erosion of his or her ability to function in ways that can exercise his/her human capability levels. Upon further reflection, and taking this line of thinking further, it can be argued that there could be conflict between the capabilities of an individual to exercise the freedom to pursue valued ends and the achieved functionings (Tipples, 2009). An example of this is urban residents who use their human capabilities to construct houses in an informal, unplanned and haphazard manner, but in the process block roads, waste water systems, and release waste water in open sewers, thus polluting the environment. The eventual outcome is poor health conditions among households. Those who are undertaking these developments are however exercising their freedoms to pursue valued ends. The foregoing examples show the human capability approach has not looked at the negative dimensions that may be caused by capability development and consequent ability of people to perform alternative functionings. It also needs to consider how to explain cases where an individual person can be forced by the social-environmental factors like an oppressive political systems or dominant culture to use their acquired capabilities to perform functions which are not welfare increasing.

2.2.1.3 Choice is not always made by Individuals, but in Many Cases Influenced by Externalities

What is defined as “valued ends” varies greatly across cultures, and between one person and another. The approach is further premised on the assumption that

individuals make decisions and choices alone, and therefore, individual capabilities can be evaluated. To the contrary, in many cases, and particularly in certain cultural backgrounds, people tend to make decisions much more in groups, and/or are influenced by the surrounding social background. The capability approach does not point-out how to measure capabilities that arise from collective decision-making. In the end, how will individual capabilities be evaluated and how the measurement of expansion of valuable freedoms can be extended to groups?

2.2.1.4 There is no Definitive List of Capabilities

The fourth limitation regards the debate on a list of basic capabilities that can be used to evaluate development. A key advocate for development of a list of minimum capabilities has been Nassbaum (2000). It should be taken into cognizance however that these are subjected to debate and objections between leading human capabilities theorists. Sen (2002) refuses to endorse the idea of developing a list. Sen argues one cannot develop a pre-determined list of minimum capabilities as capabilities should be determined through a process of choice. He further argues against a list based on minimum required capabilities as they should depend on context. He argues that different capabilities will be needed to perform different functionings to different people in different locations and environments.

This debate rages-on with UNDP (2009) arguing it may be useful to have a minimum set of universal basic capabilities in-order to evaluate policy and progress. To demonstrate this stance, UNDP (2009) developed its own list known as the Human Development Index (HDI). The HDI is made-up of indicators which measure the

levels of achieved life expectancy achieved, literacy and health as minimum capabilities. This debate marks an unfinished agenda that the approach needs to resolve and provide guidance for welfare analysis.

While there is a case to develop a definitive minimum list, this study finds it would at least be useful to develop a reference and/or guidelines for evaluation of minimum capabilities. It is not important for the list to be, by any means, universal.

2.3 Knowledge Gap

The knowledge gap arises from review of literature and served as entry-point for the fieldwork of this study. The gap analysis and entry-points are presented below as follows.

First, the literature that has been reviewed has shown urbanisation in developed countries of the global economic north was propelled by industrialization. That the factors surrounding urbanization are different in developing countries. Urbanisation trends in developing countries are driven by a globalised economy which is being subjected to adjustment measures, on the one hand, and urbanizing under poverty on the other. This has created high social inequalities in human capabilities, limiting prospects of the urban poor to cope with external global and internal intra-urban economic shocks. This study has set-out to address this gap by exploring human capability of households in informal settlements of the case-study area. This focus will enable the study to understand the nature of urbanization in LDCs and the way social inequalities influence urban poverty and urbanization. This will reveal information of how human capabilities of the urban poor are affected in the context

of adjustment, and cyclic economic fluctuations such as the current global economic downturn.

Second, literature that has been reviewed did not shed much light on socio-structural issues belonging to social networks. It is an established fact made known by authorities such as Omari (1995), Robeyns (2005) and Nondo and Coetzee (2002) that belonging to social networks contributes to social capital. This study attempts to address this gap by exploring the role of social networks in facilitating residents of the case-study area to acquire credit, continued vocational skills and productive assets to function in ways that reduce their housing and health conditions.

Third, the literature that has been reviewed for example UNHABITAT (2010) has shown the world is increasingly urbanizing, and for the first time, in 2030, it is going to reach the mark of 50 percent of the entire global population being urban. The same source has shown urbanisation trends are increasing at fastest and most unsustainable rates in SSA. The study is addressing this gap by investing the types of new challenges that these trends can introduce. The study will achieve this by investigating factors that can facilitate transformation of skills and assets of the urban poor to develop human capabilities to reduce their housing and health problems.

Fourth, the issue of social inequalities in human capabilities has been extensively documented in literature including Sen (1992) and Clark (1010). The study however finds literature has not paid attention to the existence of non-poor in deprived areas of cities. It is common-place to see that, although urban informal settlements and slums are almost synonymous with poverty, there are some people within urban

informal settlements who are able to overcome poverty and improve their housing and health conditions. The study design has taken this gap into account and will address it by examining main factors that facilitate the non-poor from acquiring elements of human capability. It will also investigate how effective these elements were in reducing poverty of housing and health in the case-study area.

Fifth, reviewed literature such as Hanson (2007) and Simler and Dudwick (2010) noted the majority of slums in recent history have developed in developing countries, and especially LDCs. The literature is by and large silent on what can and should be done to reduce development of slums in the areas. Slums are worst form of urban poverty and are often characterized by low levels of human capability development among households, poor housing and poor health conditions. This study has taken-up this challenge by validating the interrelationship between three key variables, namely social inequalities, housing and health conditions in containment of the spread of slums in LDCs.

Sixth, the reviews of the PRS, MKUKUTA I and MKUKUTA II in Tanzania has shown it lacks attention to integration of inequalities in its analysis. This is also a knowledge gap that this study has addressed. Statistical analysis that underpins the PRS, MKUKUTA I and MKUKUTA II is based on statistical data from Household Budget Surveys The review of literature has shown a major weakness of these statistics is that they are aggregate. They do not take into account high social inequality levels that are inherent in the urban economy, particularly between affluent urban areas and poor informal settlements in peri-urban areas. As a result,

the PRS, MKUKUTA I and MKUKUTA II have adopted a policy stance saying urban areas in Tanzania are affluent and on-course to attain national development targets. This study has addressed this gap by exploring the effectiveness of human capability of households in reducing housing and health status inequalities. The findings of the study aim at informing the current MKUKUTA II and future national anti-poverty strategies can take social inequalities in human capability development among the urban poor into account and function as effective welfare redistributive mechanism in urban economies.

Seventh, the review of empirical literature that has shown urban poverty is not only a condition, but is a reflection of social inequalities. However less has been said about structural poverty and its constraining limitations to the urban poor to function in ways that they wish to do in-order to achieve valued-ends. The study will address this gap to investigate the extent socio-structural relationships contribute to breeding of these inequalities. The study will identify entrenched and long-lasting structures and institutional arrangements, and their role of capability deprivations in urban informal settlements. The answers to this will start to shed light on how social-structural inter-relationships of inequality are produced and sustained, or are still needed. The answers to these questions are important since it entails from the analysis presented in this chapter that reduction of urban poverty entails a change in existing social relationships and inequalities between the urban poor and non-poor.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Introduction

The focus of this Chapter on Research Methodology is to layout how the research design was operationalised. It also describes the experimental methods that were used to systematically investigate in order to discover theories, applications and facts through the use of observations and experiments. The study follows an inductive approach that has been used in the research methodology for this study and that emphasizes the need to test a certain controlled number of a part through sensory observation by scientific experiment and then draw generalizations that are then predicted to represent the whole (Matveev, 2001; Srindhar, 2009). The inductive approach starts with perceived generalizations and moves to conduct tests of these generalizations through gathering of facts through scientific experiment and then proceed to develop new and/or modified generalizations or reject the perceived generalizations.

3.2 Research Design

Working within the overall framework of the positivist approach, this study has used multiple research methods in order to overcome possibility of errors. This approach involved the use of both quantitative and qualitative research methods. The method of combining different data collection techniques in order to minimize bias is known as triangulation. Triangulation involves using different methods to research the same issue with the same unit of analysis thus cross-checking one result with another and increasing the reliability of the result (Kennedy, 2009; Renata, 2010). Each of these

methods has its relative limitations and strengths, and therefore when used together they give a better representation of what is happening in reality (Matveev, 2001; Sridhar, 2009). The study triangulated qualitative observation research studies and quantitative questionnaire-based survey. The study also conducted a review of secondary data sources and review of empirical literature produced by researchers, scholars and academic authorities on the subject of analysis. The literature that has been reviewed informed the development of the background to the research problem, statement of the research problem, general objective and specific objectives of the study, the theoretical framework for the study and research methodology.

3.3 Data Collection Methods

The data collection methods used by the study are explained as follows:

3.4 Research Methods for Data Collection

3.4.1 Secondary Documentary Survey Method

The sources of secondary data used by this study include written texts and official documents, raw data databases, internet search, library materials and journal. This method requires critical analysis and citation of the secondary data sources being reviewed. Secondary data sources presented a number of advantages to this study. First, secondary data sources were cheaper to access and use since the data that they contained was collected, analysed and archived in libraries, statistical offices and official archives in the Government and other organizations. The use of secondary data proved advantageous to the study in that it provided data that provided background information to development of the research design and instruments, and supplemented and provided confirmation to primary data that was collected by the

study. The use of secondary data provided information from a wide range of previous studies and in the process provided valuable time series data which enabled the study to make comparisons of the issues being investigated by the study. Secondary data sources enabled the study to obtain information on experiences of urbanisation and poverty from other least developed countries and other urban areas of Tanzania and compare these findings with the case-study areas. In general, information from secondary data sources was instrumental in conducting the background to the problem to the study, situational analysis of urbanisation and poverty in the case study areas, subsequent literature review and development of the research design.

Secondary data sources were also instrumental in the development of the field survey questionnaire and in providing further evidence to analyse and explain data findings from the field. The use of secondary sources including nationally representative surveys, official government statistics and published materials such as classical text books on welfare analysis, journals, academic theses and articles were used to provide authority to the research arguments and overall research design of the study. The study also used secondary sources from academic websites including that of the Human Development and Capability Association at http://www.capabilityapproach.com/index.php to gain information and follow-up on current academic discourse on social inequalities in human capacity development. This allowed the study to benefit from a wide range of current scholarly work on the development implications of social inequalities in human capacity development. Other secondary data sources that were accessed through the internet were online databases notably the Tanzania Socio-Economic Database that is being maintained by Tanzania's National Bureau of Statistics (www.tsed.org).

This notwithstanding, it suffices to note that the use of secondary data sources had its own limitations. First the methodologies that inform the different secondary data sources that were consulted by this study were different. It therefore became difficult to make comparisons between findings from different secondary data sources because the methodologies that informed their conclusions were different. Second, the operational concepts that underpinned their design and analysis were also defined differently. It was therefore not always clear what the concepts mean or how they differ from one secondary data source to another. Third, important criteria such as geographical areas and units of measurement also differed from one secondary data source to another. This made it difficult to make comparisons between findings from different secondary data sources. Some of them analysed the case-study areas from data that is confined to Dar-es-Salaam Region as a whole in rare cases Ilala Municipality. The fourth limitation was that some secondary data sources did not publish the estimated measurement or margin of errors, reliability, bias and timescales. It was therefore not possible to estimate the inaccuracies in measurement such as the standard deviation and standard error of the data that the study was consulting. This made comparisons very difficult particularly when the study came across a source that contradicts mainstream assumptions.

The foregoing is an area of concern since some secondary data sources are produced by sources that have vested interests to present an optimistic or pessimistic set of results. This is a concern particularly for official government statistics where some have attempted to portray the picture that urban poverty is decreasing when other sources point-out it is increasing. Some factors that were found to affect the

reliability of secondary data that were consulted by this study included sample size used, response rate from survey respondents, questionnaire design, modes of analysis used, sample stratification and alterations.

Fifth, the time period which a secondary data was first compiled had a substantial effect upon the relevance of its data and information to the analysis of the study. Some secondary data sources that the study wished to consult were out-of-date. As a result of the foregoing limitations, the study used secondary data sources cautiously and in many cases limited their use to providing authority and to validate arguments and conclusions of the study itself. Secondary data sources have also been used to make comparative analysis between urban poverty conditions in the case-study areas and other urban areas within and outside Tanzania. Secondary data sources have been instrumental in revealing areas within the subject under study that have already been researched and limitations of their findings. The review of secondary data allowed the study to identify knowledge gaps in the field of study and position itself to make inventive contributions to the area of study. Secondary data sources complemented the study's primary data and enriched its analysis.

In order to validate and complement secondary data sources, the study also collected primary data. Primary data is defined as data and information that is observed, measured or collected directly from firsthand experience (Mashall, 1998). The study's primary data was collected through a structured quantitative questionnaire survey and an unstructured qualitative in-depth focus group interviews. Primary data was also collected from conducting non-participant observations in the case-study

areas. The next subsection present how the study approached these data collection methods.

3.4.2 Research Methods for Primary Data Collection

3.4.2.1 Quantitative Structured Questionnaire Survey

According to Du Cresi (2001) a structured questionnaire is a form containing a set of questions addressed to a statistically significant number of respondents as a way of gathering information for a survey. Structured quantitative questionnaire survey is associated with the positivist perspective which include undertaking cross-sectional and longitudinal studies using questionnaires or structured interviews for the purpose of data collection with the intent of codifying observations into statistical measurements which can be seen, analysed, interpreted and generalizations drawn from a sample to a population (Hec, 2001; Matveev, 2001). The method entails using data collection instruments to collect data in order to yield statistical data. The study drew several benefits from using structured quantitative questionnaire survey. First, the method enabled the study to develop a set of uniform, structured questions that were directly drawn from specific objectives of the same questions asked to all respondents of the study in the case-study areas. This ensured a direct link between the study's objectives and the survey instruments that were being used for data collection. By extension, this ensured the data that was collected and analysed responded directly to the study's specific objectives. Secondly, the choice of using the structured quantitative questionnaire made it possible for the study to clearly and precisely specify the independent and dependent variables identified in the background to the study, objectives and research questions. The variables that define

the problem of urban poverty in the context of Tanzania are social inequalities in human capability development, poor housing and poor health conditions among households. The study used the questionnaires to investigate and validate these variables in the case-study area.

This is an important aspect given the positivist approach that underpins the study's field research work. By putting the key variables and specific objectives in a structured questionnaire, the study was able to collect information on correlation and association between cause and effect variables and therefore draw generalizations which can determine future trends regarding social inequalities in human capacity development levels and urban poverty in the dimension of housing and health conditions in the case-study areas. Positivism is premised on the view that the world and the universe are deterministic and can therefore be discerned by application of a unique approach of the scientific method (Sridhar, 2009).

Thirdly, by using the structured quantitative questionnaires the study was able to address a large number of respondents, and as a result, achieve higher reliability of data due to larger, controlled samples and elimination or minimization of subjectivity of judgment associated with qualitative interviews. To this end, a structured questionnaire survey of the study with a sample of 200 households was administered in the case-study areas. The questionnaire had 33 structured pre-determined questions which were administered to heads of households. A larger sample meant the study was able to make deeper analysis across the sample as well as to make comparisons, associations and regression analysis of different variables across the entire sample of the study.

Having noted the above advantages, the study also takes cognisance of the fact that structured quantitative questionnaire survey approaches have also got their own limitations. The first limitation is structured questionnaire survey method does not provide a researcher with the underlying information on the context and dynamics behind observed trends (BOSS, 2010). Structured questionnaires mainly provide the distribution and trend of the phenomenon of analysis, but it does not provide the underlying experiences including how, why, in which context and under what prevailing terms observed trends have occurred. In other words, it does not provide the qualitative information between observed quantifiable results.

Secondly, structured quantitative survey methods cannot control the interview environment where the respondents provide the answers to the questions in the survey. There are issues of clarification and/or climate setting that can be done in unstructured interviews. Thirdly, structured quantitative questionnaires limit outcomes of a study to only those areas which are probed by questions in the questionnaire. This is due to the closed type of questions used in the structured questionnaires.

3.4.2.2 Unstructured Qualitative In-Depth Discussions

Unstructured qualitative in-depth discussions data collection technique is one where a researcher makes a knowledgeable claim and sets-out to collect open-ended data from the views of the research participants with the primary intent of developing themes or generalizations from the data (Pring, 2000). This study used this method as a follow-up to the structured quantitative questionnaire survey. Follow-up probing

questions which are possible in unstructured in-depth interview surveys can be useful to identify contradicting and unexpected responses. Such probing can also be instrument in probing and discovering unintended responses which can be important to the overall study by questioning the research design as well as assumptions that underlie the research topic (www. chronic poverty.org). As already stated above, the study has addressed these limitations by triangulating different data collection methods.

Since the quantitative survey is structured it provided structured answers to standards questions which were asked by the study. However, there were still unanswered questions on trends behind observations of key variables that were being investigated. The structured question provided information on the status of the variables under investigation but did not provide information on the subjective experiences of the respondents and actual experiences behind how such experiences have occurred. The findings of the structured questionnaire survey provided a picture of the state of affairs of urban poverty in the case-study areas and its various distributional trends; but not description of the nature of urban poverty in the case-study areas.

In order to overcome this limitation, the study conducted unstructured qualitative in-depth discussions. Instead of administering standard questions and getting structured answers, these discussions allowed respondents to wonder-off and follow through some interesting leads which can explain the respondents personal experiences, causes and effects as well as dynamics behind the key variables of the study. The

unstructured qualitative interviews were also used for follow-up and seek explanations of certain unanticipated trends that came out of the structured quantitative questionnaire survey and therefore needed further explanation. In this regard, it suffices to say that the two primary data collection techniques complement each other.

The unstructured qualitative in-depth interview survey was able to obtain in-depth description of social experiences and dynamics that could not be captured and explained by numerical data and statistical analysis used in structured quantitative questionnaire survey methodology. This was possible because unstructured qualitative research method allowed more flexible ways to undertake data collection, instant analysis interpretation of data and information that is being received and therefore provide a holistic view of the subject of analysis. When the two methods were combined, they made it possible for the study to identify facts and minimize errors and bias. It should not go without notice however that unstructured qualitative interviews methods have got their own limitations. Mcneil and Chapman (2005) mentions four key limitations of qualitative research methods.

First, if not carefully structured, there is a danger for a qualitative research project to depart from the original objectives of the research in response to the changing nature of the research context. This may therefore lead to development of generalizations that may not be useful in contributing to specific research questions and knowledge gaps that prompted a particular study or research to be taken.

Second, due to its orientation of not paying too much emphasis to logical and systematic sequence in conducting research, two unstructured qualitative interview

methods that focus on the same topic and using the same information can arrive at two completely different conclusions depending on the context of the study. Lacking consistency in conclusions of research raises a serious question of reliability of results. This limitation is compounded by the fact that although unstructured qualitative survey techniques employ the use of different probing questions, the obtained data and limitation can have bias in the sense that respondents are at liberty to choose to tell some particular facts and ignore others.

Third, unstructured qualitative interview techniques present a danger for a researcher to become influenced by the group under study, as a result the research findings can contain bias and error either in favour or prejudiced against the group. The fourth limitation concerning the unstructured qualitative interview technique is the time and cost of conducting them is high. It takes a longer time to reach fewer number of respondents compared to structured quantitative questionnaire surveys. This is why whereas this study addressed a sample of 200 respondents in its structured quantitative survey, the unstructured qualitative interviews were only 50.

3.4.2.3 Non-participant Observation

Non-participant observations data collection method involved conducting transcend walks across the case-study areas while observing key observable aspects related to the study's research questions and specific objectives. It also included an observation of various economic and income generation activities undertaken by residents in the case-study areas as well as the social, community and environmental conditions. Non-participant observation data collection method was conducted prior to

commencement of the fieldwork and prior to development of the survey questionnaire.

This method enabled the study to conduct a rapid assessment of the urban poverty situation in the study area and get first hand observations of the study's key research variables. This information provided inputs to the development of the research design and planning for fieldwork. In the latter, non-participant observation method assisted in identifying the case study's physical administrative demarcations, main geo-ecological zones, housing and human settlement patterns and socio-economic activities. The findings from the non-participant observation provided familiarity to the case-study areas which became very useful when conducting in-depth focus group discussions. There is however one limitation of participation observation data collection method. If the researcher is overtly participant, then there is a risk of modifying the behaviour of the respondents. This is because people do not behave normally when there is a stranger or when they know they are being observed http://wiki.answers.com/Q/Disadvantages_of_participant_observation#ixzz1B0uxFyUt).

All the foregoing methods were triangulated and served to complement each other in order to provide a most accurate assessment of the urban poverty situation in the case-study areas.

3.5 Sampling Methods

This section presents the following issues related to the sampling methods used by the study.

3.5.1 Sampling Technique

This study has chosen a purposive stratified sampling technique. A purposive stratified sampling technique involves dividing the total area of study into distinct sub-groups or stratum based on a prior purposefully identified sampling criteria and conduct a phased sampling in each stratum (Sridhar, 2009). The sampling technique criteria used for this study was housing density, in that the criteria is generally recognised as a proxy indicator of urbanization and the extent of informal unplanned urban settlements in urban areas (UNHABITAT, 2010). The criteria was chosen on the basis that the number of houses in a *"mtaa."* A "Mtaa" is the smallest administrative unit in urban areas. It is the urban equivalent of a village.

The "mtaa" government is comprised of a chairperson and six advisors, all of whom are elected. Housing density is generally regarded as an indicator of population and housing density, because, generally speaking, the higher the number of houses will mean higher housing density given administrative *"mitaas"* have more or less the same geographical size (Halla, 1996). The sampling technique for the study was divided into three strata.

The first strata included all the eight administrative *"mitaas"* of the case-study areas. The *"mitaas"* of the case-study area are Kisiwani, Mnyamani, Madenge and Malapa in Buguruni ward and Mtambani, Kombo, Mtakuja and Miembeni in Vingunguti ward. The reason for including all the administrative mitaas of the case-study area was to give all the *"mitaas"* an equal and unbiased probability to be included in the sample of the study (Sridhar, 2009). Table 6 provides a comprehensive analysis of

the population, housing, household per house density and gender disaggregation of the population of the first stratum of the sample, which also stands for the case-study areas as a whole. The information contained in Table 6 has been obtained from secondary data sources documenting mini-population and housing census which is being conducted by *"mitaa"* and Ward Executive Officers.

Table 6: Population and Housing Distribution in Buguruni and Vingunguti, 2011

"MTAA"	NO. OF HOUSES	NO. OF HOUSE HOLDS	HOUSE-HOLD DENSITY	MALE	% OF MALES	FEMALE	% OF FEMALES	TOTAL
BUGURUNI								
KISIWANI	3,224	4,233	1.3	12,841	50.8	12,459	49.3	25,300
MYAMANI	1,524	2,232	1.5	7,748	51.7	7,246	48.3	14,994
MADENGE	1,030	2,243	2.2	7,018	52.2	6,440	47.9	13,458
MALAPA	944	2,243	2.4	6,463	48.7	6,810	51.3	13,273
BUGURUNI TOTAL	6,722	11,051	1.63	34,070	50.8	32,955	49.2	67,025
VINGUNGUTI								
MTAMBANI	3,180	4,708	1.48	9,444	49	9,830	51	19,274
KOMBO	3,000	4,918	1.64	10,999	51	10,589	49.1	21,568
MTAKUJA	2,210	3,280	1.48	7,404	51.5	6,976	48.5	14,381
MIEMBENI	1,650	5,465	3.3	12,222	51	11,743	49	23,965
VINGUNGUTI TOTAL	10,040	18,371	1.8	40,069	50.6	39,119	49.4	79,207
TOTAL FOR CASE STUDYAREA	16,762	29,422	1.7	74,139	50.7	72,093	49.3	146,232

Source: Buguruni and Vingunguti Ward Executive Officer Offices Mini Census, (2011)

According to data that the study has obtained from the mini-census conducted by the Ward Executive Officers of the case-study areas, Buguruni ward has a total population of 67,025 people and 6,722 houses and Vingunguti a total population of 79, 207 people and 10,040 houses (Buguruni WEO Census, 2011; Vingunguti WEO Census, 2011). Disaggregation of Buguruni's population by sex as presented by

Table 6 above shows 50.8 percent of residents in Buguruni ward are male and 49.2 percent females. The same source reports that Buguruni has 11,051 households (or families). Likewise, Table 6 reports 50.58 percent of residents of Vingunguti are male and 49.38 female, and that there are 18,371 households (families) in Vingunguti.

The main reason why Buguruni and Vingunguti were chosen as case-study areas was high population density in the areas. The sampling criteria regarded high density as a proxy indicator of urbanization. As a result, the study was premised case-study areas would provide sufficient information on urban conditions, including social inequalities in housing and health conditions.

In-addition to the foregoing, there were two additional reasons for selecting the case-study areas. The first was the two case-study settlements had high levels of poor housing conditions (DCC, 2010; NBS, 2011). Compared to other settlements in Dar-es-Salaam such as Kijitonyama, Mikocheni, Changombe and Manzese, the case-study areas of Buguruni and Vingunguti had poor characteristics of housing conditions. The second reason was higher prevalence of social inequalities in housing conditions in the case-study areas. DCC (2009) observed construction of modern houses co-existed with poor housing conditions in the case-study areas. The study chose the case-study areas so it can measure the social inequalities. Another reason was to determine how the non-poor in the case-study areas were able to develop their housing conditions (Kiduanga, 2002; NBS, 2011).

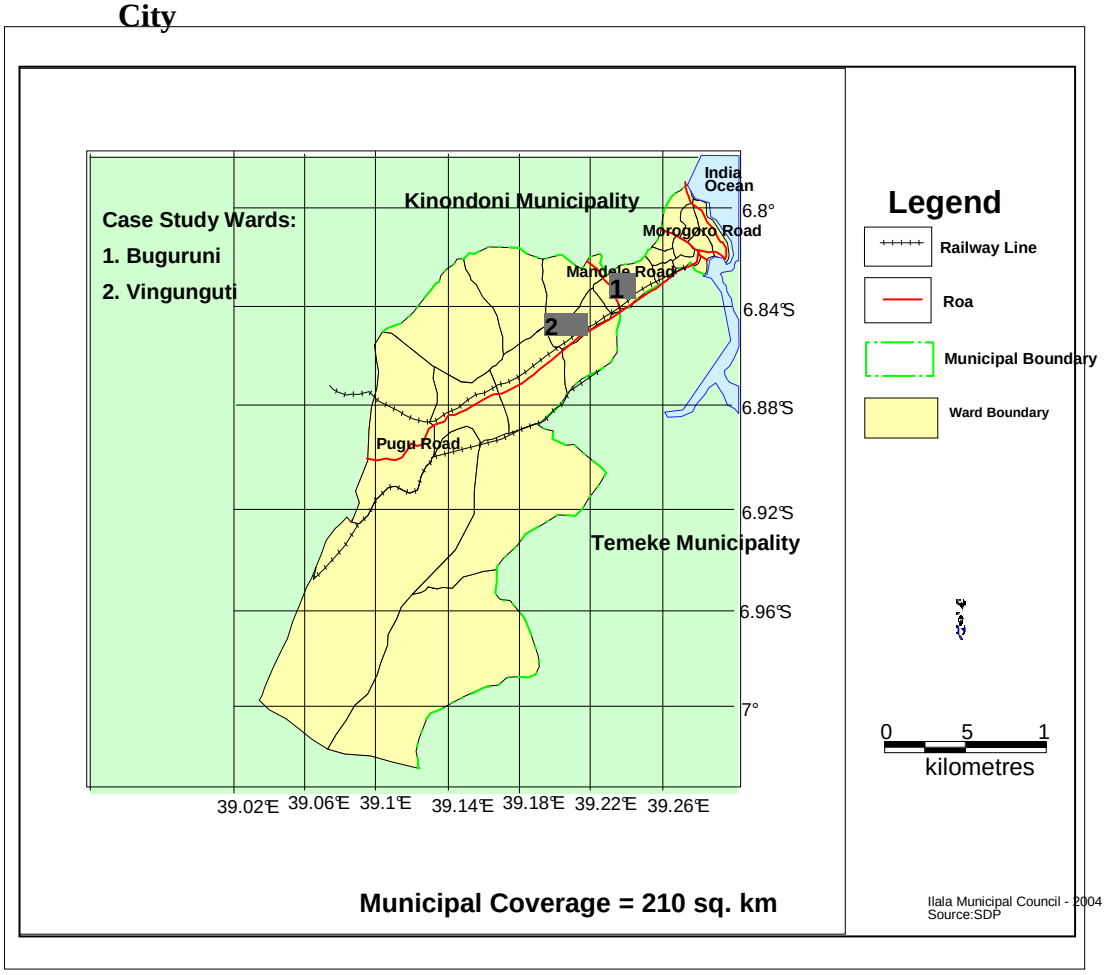
A little methodological note is warranted here to explain the difference between family and household, in that operational research makes a difference between the

two on the basis that a single, may be extended family could be sub-divided into several households. The operational definition of a household is therefore that social unit which eats from food that has been cooked from the same pot (Omari and Koda, 1996). That means, a household can be living in separate roofs for all intents and purposes, they are socially and economically linked as the same household. The concept of household helps to better capture extended families which are characteristic of the African family, even within the urban context. As it can be seen in Table 6 above that Buguruni ward has household per housing density of 1.63. Household per housing density shows the average number of households (or families) that live in a single house. This means on average, one and a third households share the same house in Buguruni ward. Table 6 shows there are inequalities in population and housing number, and housing, housing density among the different *"mitaas"* of the Buguruni ward:

The case-study areas of Buguruni and Vingunguti wards are found in Ilala municipal district, in the city's suburbs and peri-urban areas situated in the outskirts of Dar-es-Salaam city.

As illustrated in Map 1, the study areas of Buguruni and Vingunguti wards lie in the rapidly expanding suburban "middle-belt" that is characterized by high concentration of public transport infrastructure, high and rapidly growing population density, and rapidly developing unplanned squatter settlements which are characterized by poor housing conditions and poor health conditions among households. This high population and housing density is a characteristic feature of high rates and state of urbanisation (UNHABITAT, 2003; DCC, 2010).

Map 1: Location of Buguruni and Vingunguti Wards within Dar-es-Salaam City



Source, Ilala Municipal Council, (2006)

High rates of informal urbanisation are in-turn characterized by high prevalence of low levels of human capacity development of residents in the area to reduce their accommodation problems and improve environmental and public health conditions.

The case-study areas are characterised by mixed housing and land-use development patterns with a few surveyed areas and new informal settlements on marginal lands that rapidly grew during adjustment measures. The area is further characterized by high levels of social inequalities in urban housing conditions including the existence of older pre-adjustment era houses with relatively higher housing standards, a few

standard houses built at the time of when adjustment measures were being implemented, and predominance of sprawling informal settlements, including on marginal lands, with poor housing conditions, and poor environmental health standards. There are also old mud wall and grass thatched or tin roofed houses. URT-LGSP (2009) show 7 percent of households in Dar-es-Salaam have soil floors. As Map 1 above clearly shows, the case-study areas lie within Dar-es-Salaam's peri-urban areas.

As it can be seen from Table 6 above, the distribution of the sample was based on population and housing analysis for Buguruni and Vingunguti and of the respective *"mitaas"* within the two case-study wards. As mentioned above, this study has used the purposive stratified sampling procedure to divide the sample into three strata. The first stratum of the sample was purposefully and judgmentally chosen to include all "mitaas" of the case-study areas. This is a common practice in order for the total population in the case-study areas to be given an equal opportunity to enter into the sample of the study. The second stratum of the sampling technique involved purposefully choosing four administrative "mitaas" to be included in the sample of the study. The sampling technique based its selection on prior, purposefully selected, sampling criteria. The first purposefully selected criterion was to select 50 percent of the total number of the eight *"mitaas"* of the case-study areas into the sample of the study. This was done in order to make the sample of the study representative of both "*mitaas"* of the case-study areas and across the case-study areas as a whole. It was therefore purposefully and judgmentally selected that four "*mitaas,"* two from each case-study ward, which represents 50 percent of the total number of *"mitaas,"*

should be included in the second stratum of the sample. The second purposefully selected sampling criterion was to select *"mitaas"* with highest housing density.

These, as shown by Table 6 above were Kisiwani and Myamani *"mitaas"* in Buguruni and Mtambani and Kombo in Vingunguti. Based on this sampling criteria and technique, Kisiwani and Myamani and Mtambani and Kombo were the sampled case-study *"mitaas"* for Buguruni and Vingunguti respectively. The third stratum of the sampling technique involved the selection of households within the respective *"mitaas"* of the study. Households in the case-study *"mitaas"* were sampled through simple random sampling technique. This procedure involved listing the number of households in a sampled *"mtaa,"* then dividing their number with the number of households that were scheduled to be interviewed in the respective *"mtaa,"* and then households which fall under this number were chosen through simple random sampling technique. The final sample of the study involved 200 households, 50 in each *"mtaa."*

The study also conducted unstructured qualitative in-depth discussions with community members, community groups, community leaders and service centres. Table 7 presents the distribution of respondents who participated in the unstructured qualitative in-depth discussions that were conducted by the study:

Table 7: Sample of Unstructured In-Depth Interviews

WARD	Community Leaders	Community Members	Community Groups	Health Service Centres	Total
Buguruni	5	10	5	5	25
Vingunguti	5	10	5	5	25
Case Study Total	10	20	10	10	50
Percentage Of The Total Sample (%)	20	40	20	20	100

The sampling technique used to select respondents to the unstructured qualitative in-depth discussions was the clustered random sampling technique. This sampling technique involves dividing a purposely selected population into sub-groups that are homogeneous and then drawing a random sample from selected clusters (Sridhar, 2009). Using this sampling technique, the population sub-groups which were to participate in unstructured qualitative in-depth discussions were identified based on information obtained from non-participant observations review of secondary literature. These groups included community leaders, community members, community members and health service centres. Individual respondents who participated in the unstructured qualitative in-depth discussions were then identified from within each sampled sub-population groups through simple random sampling.

According to Sridhar (2009) the use of stratified sampling technique has several benefits. First, dividing the population into distinct independent strata can enable a study to draw inferences about specific sub-groups that could have been lost in a more generalized random sample. It is through the deployment of the stratified sample technique that this study has been able to make comparative and cross-sectional analysis of the case-study sub-population groups of Mtambani, Kisiwani, Mnyamani and Kombo *"mitaas."* This sampling technique had enabled the study to better portray and analyse urban poverty and social inequality dynamics within the different geographical strata of the case-study areas. This has enabled the study to undertake in-depth analysis of the internal differences and dynamics within the case-study areas, which is a vital step towards separating facts related to the impact that social inequalities across and within the case-study areas have on urban poverty.

Second, the stratified sampling technique allows a study to make inferences and generalization by conducting research in a selected representative stratum within the sample strata and then making inferences and/or generalizations to the whole; a method which is more convenient than aggregating data across the total population group of the case-study areas (Gilbert, A and Guyler, 1992; Moser, 1996).

Third, the stratified sampling technique also allows research work to focus on important sub-populations and ignore irrelevant ones. This method does not necessarily lead to less efficient statistical estimates provided that each stratum is proportional to the sub-group size in the population (Sridhar, 2009). The fourth advantage of the technique is a sample can be divided into stata and different sampling procedures and data collection techniques used in each stata in order to triangulate research findings across the groups (Kennedy, 2009).

Sridhar (2009) cautions that stratified sampling have got its limitations. First, identifying strata and implementing the stratified sampling procedure can increase the cost and complexity of sample selection as well as leading to complexity of population estimates and analysis. Secondly, when examining multiple criteria, stratification of the sample may mean there are some sample strata that are more related to the variables under investigation than others. This can contribute to measurement bias (Kennedy, 2009). This study took these limitations in consideration when developing its sampling frame. It divided the strata into homogeneous sub-grounds based on administrative *"mitaas"* which already existed, and then conducted simple random sampling across the administrative *"mitaas."* In

this regard, since the strata were homogeneous, the use of the stratified sampling approach did not introduce limitation of measurement bias.

3.6 Data Analysis Techniques

3.6.1 Quantitative Data Analysis

The study used two methods to undertake data analysis. The first was a method used to analyse quantitative data from the structured quantitative questionnaire survey and the second method was used to analyse qualitative data from the unstructured qualitative in-depth focus group survey. Data from the structured quantitative questionnaire survey was analysed through a package of statistical software for social statistics known as EpiInfo. The statistical methods that were used for analysis of the data include production and quantification of lists from the questionnaire's open-ended questions, stratified tabular analyses, percentages, average estimates across the sample, median scores, analysis of variance and correlation between key variables of the study. EpiInfo was also used to conduct data entry of data from coded structured quantitative questionnaires and processing of statistical analysis of the data and preparation of the study's statistical tabular reports. EpiInfo is modular in design in that it has various models with specific features provided through a number of linked and interrelated sub-programmes.

Following the completion of data collection from the field, the study started conducting data analysis by conducting data cleaning which involved reviewing each questionnaire to ensure answers have been indicated against all applicable questions. This exercise started during the fieldwork itself where at the end of each day, the

questionnaires were reviewed to ensure there are no errors regarding the filling-in of answers in the questionnaire. The exercise also involved ensuring there are no marks or side notes on the questions which could create ambiguity during data entry. The second step involved developing an analysis plan which included a plan that indicated which questions the data analysis exercise should associate. A third step involved data entry into the EpiInfo software. The fourth step involved commanding the software to tabulate the data in accordance to the data analysis plan. The fifth step involved reviewing the data analysis tables with a purpose to identify areas that call for further scrutiny such as seeking correlation analysis between new sets of variables. The study findings were tabulated into data sheets which were thereafter used for data interpretation and analysis.

The above-mentioned data analysis steps started with using the Eped to create the study questionnaire into the EpiInfo software. This involved creating a questionnaire and linking it to the EpiInfo database files including creating and editing programmed files for the programmed analysis of data within EpiInfo. This included creation of check files to provide for controls in order to avoid data entry error when entering data into the EpiInfo database. The Eped module was also used to create report files in order to create the format of summary tabular reports produced in analysis.

Having finished the process of creating the questionnaire variable fields into the EpiInfo questionnaire file, the study used EpiInfo's Enter module to enter data into specified fields. Before entering data into a file, the file structure must first be

created into the Enter programme using specifically formatted template or questionnaire file that is created by using the Eped module as shown above. The questionnaire file was thereafter given the required screen layout with appropriate field identifiers through which data was later entered. The specific fields that were entered under this module were numerical fields, year formats, yes/no fields and sequential id number fields. Further to this, the study used the Check module of EpiInfo to create special text files which were used to control data entry through the Enter module. Check files enabled the analysis work to include additional controls over data entry over and above the field entry specified by the questionnaire created under the Enter module. The controls that were entered using the Check module were:

(i) Setting maximum and minimum values for specified fields

(ii) Setting-up coded entries

(iii) Setting-up conditional jumps between fields where an answer at one level would mean the next level is not applicable

(iv) Setting-up no enter and must enter fields

The use of the Check module enabled the study to restrict errors that may have resulted from the data entry process. Finally, the study used the Analysis module for transformation of data into statistical summary reports. The summary statistical reports were reviewed and the analysis module was used to generate new data sets in order to make further analysis on correlation between variables of the study. This continued even to the time of drafting the final analysis chapter. In particular, the analysis module was used to generate new datasets on the well-off sub-population in

the case-study areas in order to find how they correlate with other variables of the study. This sub-group was not initially targeted for analysis by the study but since the study had segmented the socio-economic profile of respondents, it was possible to create a new dataset of the well-off. The Analysis module was used to produce lists, frequencies, histograms, bar pie and line charts, cross-tabulations, stratified tabular analyses accompanied by appropriate statistics, multiple linear regressions, analysis of variance, percentages, average estimates across the sample, median scores and correlation between key variables of the study.

3.6.1.1 Construction of the Welfare Index

Data analysis of the study involved construction of a welfare index. The welfare index was used to segment the study respondents into welfare quintiles. The welfare quintiles were constructed directly from expenditure levels that were reported by the study respondents. Note needs to be taken that the respondents from the study were chosen through simple random selection. Therefore, the welfare index allowed every respondent with an equal chance to enter into any of the welfare quintiles.

The welfare quintiles were weighed against reported daily expenditure levels as followed.

Table 8: Criteria for Welfare Quintiles of the Study Respondents

Expenditure level	Quintile
10,000 and above	Rich
5,001-10,000	Better-off
2,501-5,000	Poor
1,501-2,500	Absolute poor
1,000-1,500	Extreme poor

3.6.2 Qualitative Data Analysis

The unstructured qualitative in-depth focus group survey was analysed through a taxonomic domain technique. This data analysis technique involves recording observations and in-depth interview discussions into transcripts, classifying the recorded information into similar themes/domains, and then analyzing the data by associating and/or comparing information between the thematic/domain areas. The approach was then used to develop common categorizations and perceptions of specified social groups on urban poverty in the dimensions of human capacity development levels, housing and health conditions among households as aggregated from the in-depth focus group interviews and/or group discussions and then analysed together. Atkinson, Monica and Haj (1996) state this method has been drawn from the work of Spradley (1979) which focused on identification of the contents of qualitative data specific topics referred to as domain, and then analyzing the relationships between them. The study used transcripts of verbal responses from unstructured in-depth focus group interviews to identify primary domains, topics and/or issues of importance.

The domains of analysis were later indexed in order to identify a preliminary list of key issues as seen by the interviewees. In the process, the study created a taxonomy of sub-categories of important topics and sub-topics. In this process, the primary domains were established and other related topics were treated as secondary sub-sets to them. The taxonomic domain analysis method allowed the respondents to the study to determine the topics and issues of importance from their perspective. The next step involved starting to put the actual text into the primary domains. This

involved recording what those who were interviewed actually said about the various sub-categories of topics that had already been identified in the first two stages. After collating all responses in various sub-categories, then the process of entering qualitative data had been completed.

The taxonomy of domains constructed the overall picture of the interrelationships between the various domains of analysis. The last stage of the analysis was to identify the relationships between sub-categories and more importantly between the primary domains. The overall picture presented by taxonomy of domains was used to provide explanations to findings of the quantitative survey findings. The information from both the EpiInfo software and Taxonomic Domain Analysis were used to interpret data and information that was obtained from the field.

CHAPTER FOUR

4.0 ANALYSIS AND DISCUSSION OF RESEACH FINDINGS

4.1 Introduction

This Chapter presents empirical findings from the field and provides a discussion on the dynamics relating to human capability development. The intention is to examine the extent of household's capacity in improving their housing and health conditions. The Chapter also intends to present the extent to which urban poverty and social inequalities are being reduced in the sectors of housing and health.

4.2 Levels of Human Capability Attained by Households in the Case-study Areas

Using the basic needs approach, this study has defined basic capabilities comprising a composite index that includes education attainment, health conditions attained, and housing conditions. The study findings on levels of achievement of these basic capabilities in the case-study areas of Buguruni and Vingunguti is summarised by Table 9.

Table 9 shows there were variations in attainment of different basic capabilities among households in the case-study areas. Overall, respondents to the study said they had proportionally achieved more of certain types of basic capabilities compared to others. This distribution in attainment of basic capabilities is important to the understanding of urban poverty in the space of capability deprivation. The study findings show, for example, income levels and inequalities were among main factors that explained socio-inequalities in human capability attainment in the case-study areas.

Table 9: Level of Human Capability Attained by Respondents in the Case-Sudy Areas

LEVELS	WARDS			
	BUGURUNI		VINGUNGUTI	
	No.	%	No.	%
Education				
Adult education	4	8	0	0
Primary education	30	60	30	60
Secondary education	4	8	3	6
Other education levels	12	24	17	34
Vocational Skills	8	33.7	10	37.5
Health, water and sanitation				
Capability to reduce health problems	6	14.8	5	18.4
Households that do not suffer from frequent diseases	1	2	5	10
Housing and Shelter				
Built a house	28	67.6	24	87.5
Capability to reduce housing and shelter problems	32	77.4	25	90.6
No. of people living in a room				
1-2 people per room	29	59.2	28	56
3-4 people per room	16	32.5	16	32
More than 4 people per room	4	8.2	6	12

This therefore being the case, it was thought prudent for the study to start-off at this juncture by presenting its findings on the socio-economic profile of the case-study respondents as presented by Table 10.

Table 10: Socio-Economic Distribution of the Study Respondents

EXPENDITURE QUINTILE	SOCIO-ECONOMIC STATUS OF THE STUDY RESPONDENTS					
	BUGURUNI		VINGUNGUTI		MEAN	
	No.	%	No.	%	No.	%
Rich	0	0	0	0	0	0
Better-off	5	10	3	6	8	8
Poor	26	52	31	62	57	57
Absolute poor	18	36	14	28	32	32
Extreme poor	1	2	2	4	3	3
TOTAL	50	100	50	100	100	100

It can be seen from the foregoing that 57 percent of respondents to the study, the majority, were from absolute poor socio-economic background. 8 percent of the respondents were from households which were under extreme poverty conditions. This is compared to 32 percent of the study respondents that came from poor socio-economic background and 3 percent coming from better-off households.

The income quintiles used by the study were derived from daily household expenditure levels in Tanzanian Shillings (TShs). The expenditure levels were reported directly by the study respondents in response to the study questionnaire. The study respondents were asked to indicate which of the following five expenditure brackets represents the daily expenditure levels of their households in TShs.

1. 10,001 and above
2. 5001-10,000
3. 2,501-5,000
4. 1,501-2,500
5. 1,000-1,500

These foregoing income brackets represent a welfare index that was used by the study to develop the socio-economic profile of the study respondents. The index had the income bracket of Tshs 10,000 expenditure per household per day for respondents who were to be designated as coming from “rich” households. It however turned-out that none of the respondents to the study said they spent TShs 10,000 and above per household per day. There were therefore no rich income quintiles in the socio-economic profile of the study respondents.

In all socio-economic profiling of the respondents in this study, the TShs 5,001-10,000 expenditure per household per day has been used as the 1st income quintile. This income group was consequently labeled as the "better-off" socio-economic group. This quintile group was termed "better-off" because, in real terms, they could not be termed as "the reach." The reason behind this is the case-study areas experience generalized poverty conditions. The income bracket of the 2nd income quintile ranged from TShs 2,501-5,000. This income quintile was labeled as the "poor." The TShs 1,501-2,500 income quintile was labeled as "the absolute poor" and TShs 1,000-1,500, the bottom-most income quintile, was labeled as "the extreme poor."

Bagachwa (1994) and NBS (2000) state absolute poverty in Tanzania is defined as the inability to attain a specified minimum standard of living. In-order to identify the absolute poor, knowledge of the minimum standard of living is first needed. This involves identification of minimum basic human needs. These needs are commonly referred to in real terms, and constitute the absolute poverty line. This is where the term basic needs poverty is derived.

The basic needs poverty line can be adjusted in the long-run to cater for non-basic needs poverty which are expressed in relative terms (Bagachwa, 1994). In both the Tanzanian context, and literature concerning global poverty, basic needs have been defined as absolute minimum human needs that are needed for maintaining a minimum living standard and/or lead a decent human life (URT NBS, 2005; URT HBS, 2009; URT NGSRP II, 2010; http://www.tanzania.go.tz/poverty.html).

The basic needs approach to poverty as applied in Tanzania emphasises individual items of consumption and is measured multi-dimensionally rather than in-terms of a single indicator. Basic needs poverty in Tanzania has been defined overtime in three main categories. These are namely first, education, second health, nutrition, water and sanitation, and third, decent shelter and human settlement conditions (URT NSGRP II, 2010).

The reason why the study labeled the TShs 2,501-5,000 respondents as "poor" despite the fact that it is not the bottom-most income quintile is because the internationally defined poverty line for attainment of basic needs specifies the basic needs poor households as those which fall below the 1US$ PPP (Person Per Day) consumption threshold (NBS, 2009). Given a mean expenditure of TSh. 3,750.5 for the TShs 2,501-5,000 quintile, and given the average household size of 3.7 persons per house for Dar-es-Salaam that was calculated by the 2007 Household Budget Survey (NBS, 2009), the average expenditure for households under the TShs 2,501-5,000 is US$ 0.67 per person per day (at the TSh 1,500 to USD 1 exchange rate that existed at the time of fieldwork for this study). Furthermore, UCLAS and DHV (2004) state household incomes in Myamani *mtaa* in Buguruni was TShs 65,000 per month. This translates to TShs 2,170 per day. Both of these estimates are well below the 1 USD internationally defined basic needs poverty line (World Bank, 1990). This income bracket of the respondents was therefore found to be well within below the internationally poverty-line.

Absolute poverty is intensified by adjustment measures befalling urban areas. Lerisse and Kyessi (2002) note to this effect. They present that whereas households in Dar-

es-Salaam spent US$ 2.3 per day in 1990, the same household had only US$ 0.72 to spend per day in 2001. The same author further presents that it is important to note that since a significant share of expenditure is on food purchases (70 percent of monthly expenditure), such drastic decline is likely to be detrimental to the nutritional status of the urban poor. This shows adjustment measures contribute to increases in urban poverty.

This classification of the poor used by the study was further colloborated by findings from NBS (2009) on basic needs poverty. NBS (2009) showed household consumption in Dar-es-Salaam was between TShs 683.89- 1,502 (equivalent of a total expenditure of $ 0.43-$ 1 per person per day for total expenditure on food and other basic consumption expenditure i.e. medical and education expenditure) as shown by Table 11.

Table 11: Mean Expenditure Per Capita by Category of Items: Dar-Es-Salaam, 2007

Category	**Amount in TShs (PPP)**	**Amount in $ (PPP)**	**% Share of Consumption Expenditure**
Food-Purchased	668.96	0.42	50.8
Food- non purchased	14.93	0.01	1.4
Total Food	683.89	0.43	52.2
Durables	97.77	0.06	4.7
Medical Expenditure	29.14	0.02	2.1
Education Expenditure	85.25	0.05	3.9
Other non-durables	500.11	0.31	31.5
Telecommunications	106.43	0.07	5.7

Source: Calculated from NBS (2009)

Taking basic needs consumption expenditure for purchased food (which takes 50.8 percent of household consumption expenditure), medical and education expenditure which, as shown on Table 11, basic needs expenditure/consumption per capita amounts to TSh. 783.35 PPP (purchasing power parity). This is equivalent to US$ 0.49 PPP for Dar-es-Salaam. This level of household consumption in Dar-es-Salaam is found to be well below the 1$ international PPP threshold for basic needs poverty (NBS, 2009).

Having provided an explanation for the methodology that was used to categorise the study respondents into socio-economic quintiles, we now return back to Table 10 (pp 87) above to provide further analysis of the socio-economic distribution of the study respondents. The study findings show the majority of the respondents to the study said they came from households that spent between TShs 2,501-5,000 per household per day. This income bracket constituted respondents that were categorized to have come from absolute poor households. 57 percent of the study respondents said they were under this category, forming the 3rd income quintile of the study. The socio-economic profile further classified 32 percent of the study respondents as poor, and 8 percent extreme poor.

As already stated above, none of the study respondent said they commanded an expenditure-level of TSh. 10,000 and above a day. Had they been there, this expenditure level would have categorized respondents under this income bracket as fairly or relatively "rich." Only 8 percent of the study respondents had an expenditure level of TSh. 5,000-10,000 per day, which categorised them as "better-off."

An important point to take into consideration is the majority of the study respondents, 57 percent, were categorized under the 3rd income quintile. This means the majority of the study respondents were absolute poor. This finding provides evidence that at the time of this study, harsh poverty conditions existed in the case-study areas. Despite prevalence, the socio-economic profile also recognized there were relative differences in the depth of poverty in the case-study areas. The findings showed significant proportions of the case-study areas, 32 percent, were categorized as absolute poor. The findings further show yet a further 8 percent of respondents in the case-study areas were extremely poor.

The foregoing findings show reported proportions of poverty being much higher than those reported by NBS (2009). NBS (2009) and RAWG (2012) report poverty levels for Dar-es-Salaam as a whole were 16.4 percent for basic needs poverty and 7.5 percent for food poverty (NBS, 2009: 49). The propositions reported here are lower than the socio-economic profile constructed by this study. This is because the former covers the whole of metropolitan Dar-es-Salaam. Taking high inequality levels in Dar-es-Salaam as shown by gini co-efficient levels of 0.34 for Dar-es-Salaam, it is naturally expected that poverty-leves and household consumption levels in low income neighbourhoods such as the case-study areas to be even less (NBS, 2009).

Although this will be discussed in-depth under sub-section 4.4 of this Chapter which makes a more detailed analysis of the study findings on inequality trends, Table 9 above has shown there were income inequalities between the case-study *mitaas*. Buguruni had, for example, a slightly higher proportion of the better-offs (10 percent

compared to 6 percent in Vingunguti) but also higher proportion of the absolute poor (36 percent compared to 28 percent in Vingunguti). This shows Buguruni had higher levels of social inequalities with better-off households, mainly in planned settlements that form part of Buguruni, with concentration of poor enclaves in concentration of unsurveyed informal settlements. The study findings as shown by Table 10 (pp 87) shows that Vingunguti was characterized by generalized poverty. Vinguguti was leading in the poor household category (62 percent compared to 52 percent in Buguruni) and extreme poor households (4 percent compared to 2 percent in Buguruni). It is therefore argued that whereas Vingunguti had more widespread poverty, Buguruni had higher levels of inequalities. The following sub-section presents the study findings on each of the main basic human capabilities presented on Table 9 (pp 87) above.

This finding of the study is collaborated by findings from a survey of 16 areas of Accra city in Ghana revealed sharp disparities exist in per-capita household consumption in slum and non-slum areas. In a survey conducted by Maxwell (2000) in Dansoman – a middle income neighbourhood and two slum areas, Tema Newtown and Nima of Accra city showed per capital household expenditure in Dansoman was 3 times higher than in Tema Newtown and 2.5 times higher than in Nima. The survey further showed that households in Dansoman, the middle income neighbourhood, committed a much lower proportion of household expenditure to food. Low human capability levels, high food inflation, food poverty and insecurity were found to contribute to a myriad of poor health conditions in poor sub-urban areas. The survey further revealed that, for example, a child born in Dansoman, the more affluent sub-

urban was 8 and 10 times likely to survive compared to a child born in the slum areas of Tema Newtown and Nima respectively.

In addition to the foregoing, Simler and Dudwick,(2010) show there were high social inequalities in access to safe and reliable water supply, which has high effect on inequalities in health conditions among households. Social inequalities in access to water are manifest in Accra, for example, where poor households in unserviced urban settlements have to buy water from private suppliers at a high cost, which is often unaffordable as it reaches up to 10 percent of the monthly income of low income households (Simler and Dudwick, 2010: 47). At the sametime, high income neighbourhoods had access to constant supply of piped water at the official rate while those in middle income and poor neighbourhoods had to supplement the water from private vendors at about four times the official rate while those in the slums relied entirely on private suppliers. Such high cost of access to safe water supply often acted as barriers which limited access, and forcing poor urban households to resort to unhygienic sources of water for drinking, cooking and personal hygiene.

As a result, available literature has found inequalities to access water has negatively affected poor urban households including leading to higher occurrence of diseases, greater loss of workdays and higher outlays of expenditure, including for medical attention (World Bank, 2002; Simler and Dudwick, 2010). It naturally follows that these intra-urban social inequalities were responsible for increasing the burden of disease and poverty on urban inhabitants who live in poor urban neighbourhoods as had been observed in Accra.

4.2.1 Education Attainment among Households

Table 9 (pp 87) presents the levels of human capabilities attained by respondents in the case-study areas. It can be seen that primary education was the most widely achieved education level in the case-study areas. 60 percent of respondents in both the case-study wards of Buguruni and Vingunguti had completed primary education level. This widespread attainment of basic capabilities in primary education in the case-study areas is a clear reflection of the contribution and impact of public investment policies such as the Universal Primary Education (UPE) policy that was implemented over the long-term. Beginning in the 1970s before being temporarily suspended during adjustment measures, the Primary Education Development Programme (PEDP) was re-adopted again with the introduction of the PRS/MKUKUTA in the early 2000s. This finding of the study is confirmed by URT-LGSP (2009) which shows 70.5 percent of respondents in the three municipalities of Dar-es-Salaam city Region had attained primary education as highest level of education achieved. This included the case-study *"mitaas"* of Myamani (78.4 percent), Mtambani (75.8 percent) and Kombo (63.8 percent) (URT-LGSP, 2009). This confirms that there was generally widespread attainment of basic capabilities in attainment of primary-education in the case-study areas, and that it was evenly distributed, by gender and among poor households as shown by Table 12.

It can be seen from the foregoing Table that there was gender parity at primary education level. 30 percent of both male and female respondents said they attained basic capabilities at primary education-level. Slight gender disparities were observed in post primary education. 8 percent of males said they attained secondary education

compared to 6 percent females. This accounts for a 2 percentage point difference in favour of men.

Table 12: Distribution of Levels of Education Attained by Gender

LEVELS	GENDER			
	MALE		FEMALE	
	No.	%	No.	%
Education				
Adult education	4	8	0	0
Primary education	30	60	30	60
Secondary education	4	8	3	6
Other education levels	12	24	17	34
Vocational Skills	8	33.86	10	37.5

It can also be seen from Table 12 show that women had an advantage over men in developing their human capabilities in “other” education levels attained and vocational skills. 34 percent of female respondents said they had attained “other” educational levels compared to 24 percent males. This is a difference of 10 percentage points in favour of females. Regarding vocational skills, the study findings showed there were slight gender differences of 3.64 percentage points in favour of women. 37.5 percent of the study respondents who said they had attained vocational skills were women compared to 33.86 percent male. The study finds higher participation of women in the informal sector economy as a factor that contributed to more access of vocation skills capability development compared to men.

Drawing from the socio-economic profile of the study presented by Table 10 (pp 87) above, the study now turns to present a cross-tabulation of the study findings on the

distribution of education levels attained across the different socio-economic quintiles of the respondents to the study as shown by Table 13.

Table 13: Education Levels Attained by Socio-Economic Quintiles

Levels of Education Leveis Attained	SOCIO-ECONOMIC QUINTILE											
	Rich		Better-off		Poor		Absolute Poor		Extreme Poor		Total	
	No.	%	No	%	No.	%	No.	%	No.	%	No	%
Adult education	0	0	0	0	3	75	0	0	1	25	4	100
Primary level education achieved	0	0	6	10	29	48.33	23	38.33	2	3.33	60	100
Secondary level education achieved	0	0	1	14.29	5	71.43	1	14.29	0	0	7	100
"Other" levels of education achieved	0	0	1	3.45	20	68.97	8	27.59	0	0	29	100
Total	0	0	8	6.9	57	65.9	32	20.05	3	7.08	100	99.93[4]

It can be seen from Table 13 that a higher proportion of respondents to the study who had secondary education also said their daily expenditure was between TShs 5,001-10,000, who were categorized as "better-off" households. It is however also revealing to learn that 10 percent and 3.45 percent of respondents who said primary education and "other" levels of education where highest levels of education achieved respectively had managed to develop their socio-economic status to that of better-off households. It is equally important to note that 75 percent (3 respondents) among the study respondents who said they had attained adult education as highest level of education attained were able to develop their socio-economic status to 3rd income quintile, effectively moving out of extreme and absolute poverty status.

[4] The difference of 0.07 is due to 'rounding-off' of decimals

Proportionally, Table 13 shows the study respondents who said they had secondary education as highest level of education were leading in the proportion of the study respondents who were ranked under the 3rd income quintile and thus effectively overcoming extreme and absolute poverty (71.43 percent), followed by those who had attained "other" education levels (68.97 percent) and then followed by those who had attained primary education as highest level of education attained (48.33 percent). It is of interest to note that there was a higher proportion of the study respondents who said they had attained adult education and "other" education who also managed to command expenditure levels to the 3rd income quintile, thus overcoming extreme and absolute poverty levels, compared to respondents who had completed primary education.

As it can be seen from Table 9 (pp 87) above, the attainment of secondary education was both low, and unevenly distributed across the case-study areas. Only 8 percent and 6 percent of the study respondents from Buguruni and Vingunguti respectively said they had attained secondary education. This is a significantly lower proportion compared to 60 percent of respondents who had attained primary education across the case-study areas as a whole. This shows there was a sharp decline from capabilities of households to attain primary education to attainment of secondary education. This sharp decline raises curious questions which call for further investigation on main barriers for households to attain secondary education.

To this end, the study findings presented by Table 13 are telling. It comes-out clearly that income levels were the main constraining factor for households to attain human

capabilities in secondary education. The study finds show there was a gradual decline from the 2nd, to 3rd quintile, which represents poor and absolute poor households; to none among households from extreme poor socio-economic background. It can also be seen from Table 13 that there was a positive correlation between household incomes and attainment of human capabilities in education attainment. It can be seen for example, whereas only 2 respondents (3.33 percent) from extreme poor households said they had attained primary education, 23 respondents (38.33 percent) and 29 respondents (48.33 percent) said they had attained primary education from the absolute poor and poor households respectively.

This finding is collaborated by Simler and Dudwick (2010) and UNHABITAT (2010) who state income inequalities is a prime factor that reduces prospects for children and youth from poor urban households to improve their human capability development levels through attainment of education. UNHABITAT (2010) reports for example, while net enrollment ratios in Zambia and Zimbabwe increased in non-slum urban areas and rural areas, they decreased in slum areas. In Guetamala only 54 percent of children living in slum areas were enrolled in primary school in 1999 compared to 73 percent in non-slum urban areas and rural area. In Bangladesh, Nepal and Pakistan whereas fewer than 40 percent of children in urban informal settlements complete primary education, 70-80 percent compete primary education in non-slum parts of urban areas. In Sierra Leone the figures are 20 percent in slum areas and 70 percent in non-slum areas, and in Bolivia 10 percent in slum areas and 55 percent in non-slum areas. In Nigeria children from slum areas are 35 percent less likely attend school compared to those from non-slum urban areas (UNHABITAT (2010).

The study findings as shown on Table 13 show the same correlation between household income and attainment of human capabilities in education levels attained were observed in attainment of “other” education and secondary education levels. Whereas none of the respondents from extreme poor households attained “other” education levels, 8 respondents (27.59 percent) and 20 respondents (68.97 percent) from absolute poor and poor households respectively attained “other” levels of education. None, 1 respondent (14.29 percent), and 5 respondents (71.43 percent) attained secondary education from the extreme poor, absolute poor and poor households respectively. All of the foregoing study findings provide evidence that a strong correlation between household income and human capability development in attainment of education levels among households existed in the case-study areas. This finding shows, effectively, household incomes serve as a barrier to development of human capabilities in education among households in the case-study areas of Buguruni and Vingunguti.

The study findings show, for example, on Table 19 below (pp 126) under Section 4.2 on Contributing Factors to Human Capabilities Development that out of the 3 respondents from extreme poor households that are shown above on Table 12 had managed to use their adult education and primary education levels to attain formal employment (1 respondent, 33.33 percent) and self-employment (2 respondents, 66.67 percent). The study findings further showed capabilities in attainment of education and formal/self-employment that were attained by the 3 respondents from extreme poor households (7.08 percent of respondents to the study) had enabled 33.33 percent (1 respondent) among them to access credit. The rest of the 2

respondents (66.67 percent) among them, had however, not been able to access credit.

As shown by Table 20 below (pp 127) on Access to Credit by Expenditure Quintile under section 4.2 on Main Factors that Contributed to Failure of Households to Attain Some Elements of Human Capability Development, low income levels served as a barrier for extreme poor households to access credit. That is why, overall, only 1 out of the 2 respondents (33.33 percent) from extreme poor households accessed credit. None of the 3 respondents from extreme poor households said they had made improvements on their housing conditions being roofs, while all of the 3 respondents (100 percent) said they had made improvements on walls (100 percent).

Low capability levels in education, access to credit and other vocation skills training means the urban poor typically have low capabilities to improve their housing conditions. As a result, they make improvements by bits and pieces. The poor make partial improvements because their houses are in the first place of poor quality, and need regular improvements and/or because of meager incomes to make full improvements. The findings of the study show only 1 respondent among the 3 respondents from extreme poor households had been able to build a house. Additionally, the study findings show all 3 respondents from the extreme poor households said they did not own any productive assets, and all the 3 respondents said they had frequently suffered from diseases being 2 respondents (66.67 percent) and 1 respondent (33.33 percent) who said they suffered from malaria and other diseases respectively. Irrespective of the fact that these 3 respondents from extremely

poor households (100 percent) suffered frequently from malaria and other diseases, they study findings show all the three 3 respondents from extremely poor households (100 percent) accessed health services. The foregoing findings provide useful information on the relationship between inequalities in human capabilities and poor housing conditions in urban areas. This provides a basis for better conceptualization of human capacity development trends to address urban poverty in housing and health conditions in the case-study areas.

Although a minority, Kiduanga (2002 and UNHABITAT (2010) argue there are some households in predominantly poor urban informal settlements that have been able to acquire sufficient consumption capabilities to improve their housing and health conditions. With improved housing conditions, including running water and sanitation, these households also tend to command improved health conditions. These same households tend to invest in acquisition of basic capabilities such as education, access to credit, membership of social networks and productive assets. In the process, they improve their prospects of expanding consumption capabilities to improve their immediate housing and health conditions. This becomes an ongoing process that causes a widening gap of social inequalities between the poor and non-poor, leaving the capability deprived in a poverty trap. Without consumption capabilities other forms of human capabilities cannot be sustained. The application of Nondo and Coetzee (2002) definition of human capabilities to urban poverty as capability deprivation appreciates the fact that quality and skilled labour is an important starting point in human capability development. The quality of labour is closely associated to access and or ownership of productive assets. The level of

integration of urban households to social networks, including financial intermediary organizations, is also found to be an important dimension of human capability development.

It can therefore be deduced from the findings that the extreme poor in the case-study area were able to access education services, mainly adult education and primary education, and had managed to make small improvements in their housing conditions, particularly the floor and walls. The findings however show that their income status did serve as a barrier for accumulation of key capabilities needed to improve their health and housing conditions. As a result of low human capability development levels, the study respondents from extreme poor households did not fare well in reducing their housing and health problems. Only 1 respondent among them accessed credit and all of them did not own a productive asset. Consequently, none of the 3 respondents from extreme poor households made improvements on their roofs and all of them suffered from frequent preventable diseases.

In addition to the above-mentioned finding, the study obtained additional data from key informant interviews that showed settlement and housing conditions in the case-study area is also another determinant factor behind low access to basic needs services such as secondary education. According to UNHABITAT (2010), housing and settlement conditions includes access to essential settlement services such as water, education and health facilities, sewage services, access roads and public health services (UNHABITAT, 2010). As it can be seen, a significant portion of housing and settlement conditions contributed to basic human needs. The study was informed

that haphazard and informal shelter and settlement conditions in the case-study areas had contributed to increased urban poverty in dimension of poor housing and shelter conditions, as well as low achievement in basic needs capabilities among households.

In realizing the importance of serviced settlements to human capacity development and health conditions among urban household, the Government of Tanzania through the PRS/MKUKUTA initiated the Community Infrastructure Upgrading Programme (CIUP) which compensated households to be re-settled elsewhere in-order to obtain extra space to develop essential community infrastructure in informal unserviced settlements in the case-study areas (CIUP, 2009). The study found this measure had been effective in introducing basic services which contribute to development of basic human capability. Other basic needs that were targeted by the CIUP included to acquire land for construction of facilities such as primary and secondary schools, dispensaries, water and sanitation infrastructure and feeder roads. The study finds measures such as the CIUP positively contributed to widening access to development of basic capabilities to increase household access to attainment of affordable secondary education among poor households in the case-study areas.

The study findings showed those who had not managed to achieve secondary education typically developed their basic capabilities through attending “other” education levels. “Other” education levels were defined by this study as continuous, post-formal education that was provided through continuing education, usually in the form of entrepreneurship training in the informal sector. Given the prevailing low

transition rate from primary to secondary education, “other” education levels provided an important and primary means of human capability development among poor households in the case-study areas. As it can be seen from Table 9 (pp 87) above, a significant proportion of the respondents to the study said they had been able to develop their human capacity levels through “other” types of education. 34 percent and 24 percent of respondents in Vingunguti and Buguruni wards respectively said they attained “other” education levels which have enabled them to function in ways that improve their basic human capabilities. This finding shows, upon completion of primary education, there was a larger proportion of the study respondents who went-on to develop their capabilities through “other” education levels compared to those who pursued secondary education. A main reason behind why a larger proportion of respondents to the study were able to develop their capabilities through “other” education levels is its affordability in-terms of costs. This is because “other” education levels are provided by various non-governmental organizations (NGOs) which are active in the informal sector economy. Table 14 presents the study findings that show “other” education levels attained had been an important means of households to develop their basic capabilities and to satisfy their other basic needs such as housing and health conditions.

Table 14: Basic Capabilities Attained by Education Levels

LEVELS OF EDUCATION LEVELS ATTAINED	**IMPROVED HOUSING AND HEALTH CONDITIONS**			
	BUGURUNI		**VINGUNGUTI**	
	No.	**%**	**No.**	**%**
Adult education	2	12.03	0	0
Primary level education achieved	17	59.80	15	62.5
Secondary level education achieved	1	2.94	1	4.16
“Other” levels of education achieved	8	26.73	8	33.33

Table 14 shows although higher proportions of the respondents to the study with primary education said their main economic activity had helped them to improve their housing and health problems, respondents who attained “other” levels of education also constituted significant proportions among them. 26.73 percent and 33.33 percent of the study respondents who had improved their main housing and health problems in Buguruni and Vingunguti respectively had “other” education levels as highest level of education attained. It can further be noted that there were higher proportions of “other” education attainers who said their main economic activity had helped them to reduce their housing and health problems compared to secondary education attainers. Only 2.94 percent and 4.16 percent of respondents in Buguruni and Vingunguti respectively who said their main economic activity helped them to reduce their housing and health problems had secondary education. These finding points to the importance of human capabilities built through “other” education services. The finding suggests “other” education levels were effective in developing basic capabilities among households, principally through developing skills through primary and “other” education levels, which, in-turn, enabled them to transform their assets into capabilities and to function in ways that reduced their main housing and health problems. This is illustrative of findings by Robeyns (2005). He argued that access to elementary functionings is instrumental as a stepping stone to ability to function in more complex ways. This view is also suggested by Sen (1999) who argues a person’s capability is premised on the various combination of elementary and complex functioning that a person can achieve.

In the same vein, the study findings showed there was a positive correlation between the attainment of “other” forms of education and capabilities to participate in income

generating activities. This is evidenced by the findings of the study that showed 54.5 percent and 25.7 percent of respondents from Vingunguti and Buguruni wards respectively that had “other” forms of education levels were self-employed. Table 15 shows this relationship by cross-tabulating the study findings on levels of education attained, proportion of respondents who were self-employment, ownership of small businesses in the informal sector and formal employment.

It can be seen from Table 15, “other” education services has made significant contributions to development of capabilities of the study respondents to undertake gainful income generation activities. As it had already been stated above, 25.7 percent and 54.5 percent of respondents from Buguruni and Vingunguti wards respectively said “other” education services was the highest level of education attained. This is an indication that “other” education services placed an important role in expanding human capabilities of households in the case-study areas to be able to function in self-employment. Likewise, the study findings show 43.2 percent and 43.3 percent of the study respondents from Buguruni and Vingunguti wards respectively attained “other” education levels said they were able to expand their human capabilities in ownership of small businesses in the informal economy. The study finds their ability to function in these ways and in the process to access household incomes was instrumental in transforming their skills and primary income into basic capabilities to improve their housing and health conditions. This finding of the study is supported by the findings of Nondo and Coetzee (2002). Their findings present human capabilities being developed from the dimension of the quality of their labour, ownership of productive assets, extent of human and social capital acquired, and consumption capabilities achieved.

Table 15: Self-Employement by Education-Level Attained

EDUCATION LEVELS ATTAINED	FORMAL-EMPLOYMENT				SELF-EMPLOYMENT				SMALL BUSINESSES			
	BUGURUNI		VINGUNGUTI		BUGURUNI		VINGUNGUTI		BUGURUNI		VINGUNGUTI	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Adult education	1	5.5	0	0	1	8.3	0	0	1	4.5	0	0
Primary level education achieved	8	94.	5	87.5	11	97.7	14	88.9	11	91.4	11	96.6
Secondary level education achieved	1	16.6	1	12.5	2	9.09	1	3.3	1	6.2	1	10
“Other” levels of education achieved	2	38.8	2	25	3	25.7	9	54.5	6	43.2	5	43.3

The approach evaluates human capabilities from the extent to which labour is skilled, and by extension productive. The quality of labour is recognized to be dependent on other aspects of human development. These include health conditions, the extent to which basic formal education is achieved, and continued attainment of specialized skills which can assist individuals to function in the market place in-order to get income to meet basic needs. In their analysis, health, and education capabilities are combined and termed as human capital.

Another dimension that was mentioned by Nondo and Coetzee (2002) involve the degree of ownership of productive assets. They argue productive assets have an accelerator effect on individuals who have already attained certain levels of human capability development. They provide additional capabilities to people who have already undertaking skilled, productive quality labour, as well as being healthy and educated. This additional level of capability becomes critical to enable them to expand choices and freedoms to be who they want. Productive capabilities enable individuals to function in a more productive manner and achieve more functionings, and valued ends. By extension, productive assets become instrumental in converting skillful labour to household incomes and consumption. This “conversion” process enables the urban poor to address their poverty in housing and health conditions, thus limiting deterioration into slums. It can therefore be argued that capabilities in dimension of productive assets provide a catalytic effect to healthy and productive labour capabilities to become even more productive.

Nondo and Coetzee (2002) go further to introduce an additional element to human capabilities and that is social capital. Their approach is premised on the fact that once

labour is skilled, educated, healthy and has access to productive assets, and also needs to belong to social networks. Social networks include being “connected” as a member to reciprocity networks for pooling income and insurance against vulnerabilities and risks. They argue that this becomes an important factor that enables individuals to overcome vulnerabilities to intermittent shocks, as well as shortfalls of certain minimum entitlements such as access to credit. The same authors argue that this social capital enables individuals to acquire and protect current ownership of assets (capacity levels) in the event of a crisis or consumption shortfalls. It therefore becomes clear that social capital is important when it comes to maintain a certain level of capability set, which is essential to achieve valued ends.

Belonging to social networks or otherwise termed as achieving social capital happens in many different ways, from small scale community self-help and reciprocity groups to modern-day insurance, social security and financial services and intermediary organizations. Being accepted in one’s community, belonging and having voice in key forums constitute social capital. Social capital allows individuals to pool capabilities and risks, and be able to temporarily draw from these networks to overcome temporary obstacles in capabilities deprivation. Social capital becomes essential when there is a need to acquire productive assets, for example, or to repair human capital in dimension of health and/or acquisition of certain specialized skills which enable an individual to perform functionings that she or he could not perform previously, to meet valued ends.

Lastly, Nondo and Coetzee (2002) argue consumption capabilities are a direct outcome of the four basic human capabilities. The previous four human capabilities

that they mentioned were quality of skilled labour, human capital, productive asset base and social capital. These capabilities determine the budget "capability set" that an individual can achieve, and be able to command consumption of a certain alternative bundle of commodities (Sen, 1999). Consumption capabilities emphasize the correlation between individual and household consumption and the other preceding capabilities. Poverty is defined as consumption shortfalls on certain basic needs, most especially household expenditure such as to improve basic housing and health conditions. It logically follows, according to Nondo and Coetzee's (2002) analysis, that once basic capabilities have been achieved, then household capabilities to attain different combination of consumables will also increase. The ability of households to achieve certain consumption capabilities also creates their abilities to acquire, manage and repair labour, asset ownership, human and social capital capabilities. This therefore shows the more basic capabilities that individual and households have, the more consumption they can command, and in-turn, the more basic and complex capacities they may acquire, retain and/or repair.

In-line with the foregoing, the study findings have provided evidence, that "other" education levels contributed to development of vocational skills as shown by Table 8 above. 37.5 percent and 33.7 percent of respondents from Vingunguti and Buguruni respectively said they had attained vocational training skills. In the case-study *"mtaa"* of Myamani for example, 20 percent of respondents said they acquired vocational trade skills such as washing and pressing of clothes and business skills. Kisiwani on the other hand 33.33 percent had acquired vocational skills. However inequalities in the distribution of this dimension of capabilities prevailed. The study

finds more respondents from Kisiwani said they had attained vocational skills because Kisiwani is an established residential area with less concentration of commercial activities in the area. Likewise, 75 percent of respondents in Kombo said they had not acquired new trade skills over the last 10 years. This was primarily because residents of Kombo disproportionately engage in agricultural activities in the adjacent flood plains of Msimbazi River. An important exception is Mtambani *"mtaa"* in Vingunguti ward where all respondents who were interviewed said they had acquired trade skills over the last 10 years. This was found to be caused by the fact that Mtambani is a long-term established community.

4.2.2 Health Conditions Among Households

The basic needs poverty approach that is currently used in Tanzania identifies health conditions among households as a basic need, and by extension as an elementary human capability. The approach recognizes that healthy conditions among households is instrumental in enabling physical capabilities to function in ways that households with basic needs. Tanzania's basic needs approach strongly correlates available clean and safe water, and sanitation, with health conditions among households (REPOA, 1994; RAWG, 2007). Duclos (2004) argues basic needs can be seen as physical inputs that are usually required for individuals to achieve some basic capabilities to achieve wellbeing.

Therefore, it can be argued that basic needs are a reflection of basic capabilities. This supports the premise that education attainment, health and housing conditions are important elements in developing basic capabilities among households (PHDR, 2009; UN-HABITAT, 2010).

It can be seen from Table 9 (pp 87) above that is presented right at the beginning of this Chapter that some households in the case-study areas had been able to improve their health conditions. 14.76 percent of respondents from Buguruni, for example said they were able to reduce their health problems. Likewise, 18.40 of respondents from Vingunguti said they were able to reduce their main health problems. This finding provides evidence that some households had attained basic capabilities to address and/or reduce their main health problems.

The study findings shown by Table 9 (pp 87) also show households in the case-study areas were not able to completely address their main problems in health. Taken as a whole, the study findings suggest these households had attained capabilities to make small improvements on their health conditions, but leaving their health problems largely persisting. In Buguruni for example, only 2 percent of the respondents said their households did not suffer from a main health problem over the last 10 years of adjustments. 10 percent of the respondents to the study from Vingunguti said their households did not suffer from a main health problem over the last 10 years. This data shows that not only the majority of the respondents to the study were still facing poor health conditions, but also they had low-levels of capabilities to address this basic health needs.

In-order to get further details on the respondents who informed the study that they did not suffer a main health problem over the last years, the study cross-tabulated this finding with expenditure quintiles of the study respondents as shown by Table 16.

Table 16: Respondents who did not Experience Main Health Problem by Expenditure Quintile

QUINTILE	DID NOT EXPERIENCE MAIN HEALTH PROBLEM IN 10 YEARS			
	BUGURUNI		VINGUNGUTI	
	No.	%	No.	%
Better-off	0	0	0	0
Poor	1	50	3	33.3
Absolute poor	0	0	1	16.7
Extreme poor	0	0	2	50

The study findings shown by Table 16 shows the trend is poorer respondents are the ones who said they did not suffer most from a main health problem over the last 10 years. As it can be seen, none of the respondents from the better-off expenditure quintile said they did not experience a main health problem. In contrast, the majority of the respondents from poor households said they did not experience a main health problem, followed by the extreme poor, especially in Vingunguti and then the absolute poor, also in Vingunguti.

Table 17: Main Health Indicators by Expenditure Quintile

Key health indicators	EXPENDITURE QUINTILE							
	Better-off		Poor		Absolute poor		Extreme poor	
	No.	%	No.	%	No.	%	No.	%
Accessed health services	8	100	57	94.74	32	90.62	3	100
Frequently suffered from Malaria	7	87.5	42	73.68	23	71.88	2	66.67
Frequently suffered from other diseases	1	12.5	12	21.05	6	18.75	1	33.33

This finding suggest the poorer the study respondents were, the less likely there were to suffer from a main health problem. In-order to investigate this trend further, the

study cross-tabulated the study findings on key health indicators and expenditure quintile as shown by Table 17.

As it can be seen on Table 17, there was nearly universal access to health services across all expenditure quintiles. The study respondents from extreme poor and better-off households reported to access have 100 percent access to health services. 3 respondents from the absolute poor expenditure quintile (9.38 percent) reported not to have access to health services. Likewise, another 3 respondents from poor households (5.26 percent) also reported not to have access to health services. The small differences could be a reflection of access to public and private health providers as well as household incomes serving as a barrier to access of privately health services.

These foregoing findings can be interpreted to show the extreme poor used public services in all instances, hence expanding their chances to access health services. Due to the crowded nature of public health services however, and given the busy nature of their activities in self-employment (46.88 and 36.84 of the absolute poor and the poor respectively) and small businesses (37.50 and 36.84 of the absolute poor and poor respectively) in the informal economy, they tended to prefer using private health services. It can be seen a few respondents from the absolute poor and poor households could not access health services, indicating that patient-health provider ratio and quality of services served as a barrier for non-extreme poor household to access public services but at the same-time, household incomes served as a barrier for absolute poor and poor households to access private health services.

As it can be seen from Table 17 above, all (100 percent) of respondents from better-off households said they had access to health services.

Table 17 above further shows whereas there were higher proportions of the study respondents from better-off households who said they frequently suffered from malaria. 87.5 percent of respondents from better-off households did, for example, report that they frequently suffered from malaria as a main health problem. This was followed by equally high proportion of respondents being 73.68 percent among respondents from poor households, 71.88 percent 66.67 percent from absolute and poor households respectively.

On the outset, this finding can be interpreted as going against conventional wisdom that poorer households would have suffered more from main health problems compared to better-off households. A converse relationship is observed when analyzing a cross-tabulation of the study findings on proportions of the study respondents who suffered from “other” diseases by expenditure quintile. The trend between “other” diseases and household incomes were regressive (i.e. the lower the household incomes the higher proportion of households under that category reported to have frequently suffered from “other diseases.”

It can, for example, be seen from Table 17 that 12.5 percent of the respondents from better-off households reported to have suffered from “other” diseases, while 21.05 percent, 18.75 percent and 33.33 percent of respondents from poor, absolute poor and extreme poor households reported to have frequently suffered from “other”

diseases. This pattern shows respondents from poorer households were more exposed to “other,” mainly communicable diseases, while respondents from better-off households were more exposed to malaria, which may reflect lifestyle including patterns of socialization and construction on marginal lands along the Msimbazi river creek. Other diseases on the other hand could be a reflection of various factors related to housing conditions, such as lighting, ventilation and cleaner air from cooking.

Given more severe burdens of disease, poorer households did not count malaria as a main health problem. This is because they suffered from other grave communicable diseases, mainly water-borne due to water contamination, such as dysentery, pneumonia and cholera, which is endemic in the case-study areas. This finding is a reflection that poor housing and shelter conditions, and inadequately developed community and public infrastructure and amenities affects health conditions, especially among the poor who are associate with poor housing and shelter conditions.

Various other studies have reported high prevalence of diseases in poor urban informal settlements. Kampala’s urban poor for example, developed settlements on former agricultural and vacant lands on the outskirts of the city. The settled area had poor quality and inadequately serviced housing, and houses constructed on road reserves. This had led to hazardous and undesired conditions such as children playing in front of overflowing leaking latrines which contaminate drinking water sources and making these households and the settlement population vulnerable to health

outbreaks such as cholera (Nugwaba 2004; Giddings, 2009; Simler and Dudwick 2010).

Simler and Dudwick (2010) found-out for example, there were high social inequalities in the likelihood of stunting in SSA cities. These ranged from 20 percent among the poorest to almost none at all among the wealthiest in Accra. 25 percent among the poorest to under 5 percent among the wealthiest in Kampala. 30 percent among the poorest to under 10 percent among the wealthiest in Maputo.

UNHABITAT (2010) confirms this premise and reports there were sharp social inequalities in health conditions in the dimension of stunting among children in different cities in developing nations. It further reports that in Niger in 2005, 10 percent of non-slum urban children were stunted compared to 26 percent of children in slums. The trend was the same in other countries which were surveyed. In Ethiopia, 11 percent of children in non-slum urban areas were malnourished compared to 48 percent in slum areas. In Democratic Republic of Congo the figures were 16 percent in non-slum urban areas and 41 percent in slum areas; in Bolivia 15 percent in non-slum urban areas and 32 percent in slum areas; in India 21 percent in non-slum urban areas and 54 percent in slum areas, and in Bangladesh 24 percent in non-slum urban areas and 51.5 percent in slum areas.

Both Sen (1999, 2004), Nussbaum (2000), Nondo and Coetzee (2002) consider health conditions among a households' most important set of basic capabilities. Sen (1999) refers to household access to basic needs such as nourishment, escaping

morbidity and mortality and access to basic health services. Nussbaum (2000) refers to them as life and bodily health, and Nondo and Coetzee (2002) as human capital, which includes health status. A key focus of human capability development in this case would be the expansion of health entitlements to enable households to function in ways that gives them the capability to achieve valued ends (Sen, 1999; 2004).

4.2.3 Housing and Shelter Conditions

The basic needs poverty approach as it is being applied in Tanzania recognizes housing and basic shelter conditions as a basic human development need. In this context, the study investigated the level of basic capabilities development of the study respondents to improve their housing and shelter conditions. Overall, the study findings show there were sufficiently developed capabilities to improve housing and shelter conditions among households in the case-study areas. As it has been shown by Table 8 above, 87.5 percent and 68.58 percent of respondents from Buguruni and Vingunguti respectively said their main economic activity had enabled them to make improvements on their houses, therefore contributing to reduce their main housing and shelter problems.

This finding was further underscored by the study findings that showed there were a significant proportion of the study respondents who said they possessed capabilities to transform their skills and assets to improve their housing and shelter conditions. 90.6 percent and 77.39 percent of respondents from Vingunguti and Buguruni respectively said they had attained basic capabilities to reduce some of their housing and shelter conditions.

The foregoing findings show residents of the case-study areas were active in making constant improvements on their housing and health conditions. It further shows that basic capabilities in the form of education and health conditions were instrumental in developing capabilities to reduce their housing and shelter problems. Kalwani (2001) notes pit latrines were the usual toilet facilities in the squatter areas of Moshi municipality where 69 percent of its residents had only primary education. In this area, 74.4 percent of the pit latrines were found to be in poor sanitary conditions. They were found to be dirty, shabby, roofless and made-up of scrap and old materials. In contrast, 46 percent of urban residents living in low and medium density areas had at least secondary education. Among these, most of them had descent flush toilets connected to the public sewer or septic tanks. Kalwani (2001) acknowledges the above as a direct relationship between human capability development levels in education achieved and improvements in housing conditions. He argues that it is the latter's good education, managerial capabilities and income which enabled them to install high quality toilet facilities (Kalwani, 2001: 21). The study findings however show, due to prevailing low levels of human capability levels, the housing and shelter improvements that are being made are patchy, leaving housing conditions to generally be sub-standard.

Housing and shelter conditions are also responsible for respiratory infections. This health risk can be seen from the study finds on room density. 32.5 percent and 32 percent of respondents to the study from Buguruni and Vingunguti respectively said 3-4 people sleep in one room. 12 percent and 8.25 percent of the study respondents from Vingunguti and Buguruni said they sleep more than four people in a room. This

finding shows there are still low capabilities to improve housing and shelter conditions among households in the case-study areas. This raises the question of the relationship between low human capability levels to improve housing conditions, and health conditions among households.

Moore *et al* (2003), Savingy (2004) who point-out that potential health risks and hazards that presents themselves with rapid urbanization in third world countries include construction of sub-standard housing on marginal lands, overcrowding, increasing levels of air and water pollution and inadequate sanitation services. UNICEF (2003) cautions that human fecal waste is an important source of disease causing organism and probably the most single dangerous pollutant of surface water supply in peri-urban areas. UCLAS and DHV (2004) point-out the most widely used sanitation system in the urban informal settlements of Dar-es-Salaam were private pit latrines. 80 percent of households used this type of toilet. An average of three households shared one pit latrine. Very few households had water borne systems (septic-tanks) to soak-away pit systems. They cited that the main reason for this was costs involved in construction and unreliability of water supply. Kiduanga (2002) also notes overflow of pit latrines was caused by the inability of households to meet the high labour charge of emptying them. Emptying of pit latrines had to be made manually because the toilets are inaccessible to cess-pit trucks due to lack of roads.

Moore *et al.,* (2003) point-out that human fecal waste collection is a major problem in many cities in LDCs. Inadequate fecal waste collection poses a threat of developing a variety of hazards, in most cases in shantytowns which have been

erected rapidly on any available land (Moore *at al*, 2003: 273). The same authors caution that uncollected solid waste can serve as breeding sites of a variety of vectors of infectious diseases such as flies, mosquitoes, rodents and insects than can be a source of rapid epidemics in these marginal urban informal settlements.

In-order to understand further the relationship between basic capabilities among households and capabilities to improve housing conditions, the study made cross-tabulation of the study findings on education levels attained and capabilities to improve their housing conditions as shown by Table 18 below.

Table 18: Capabilities to Improve Housing and Shelter Conditions by Level of Education Attained

	CAPABILITIES TO IMPROVE HOUSING AND SHELTER CONDITIONS							
LEVEL OF EDUCATION	**Improved their house**				**Did not improve their house**			
	Buguruni		**Vingunguti**		**Buguruni**		**Vingunguti**	
	No.	%	No.	%	No.	%	No.	%
Adult education	2	3.7	0	0	0	0	0	0
Primary education	20	68.9	16	75	4	50	3	100
Secondary education	1	1.5	1	4.16	3	25	0	0
“Other” education	9	25.8	8	22.22	2	25	0	0

It can be seen from Table 18 that there was no clear pattern to explain which capabilities were instrumental in making the respondents to the study to improve their housing conditions. Primary education still accounted for the majority of those who improved their housing conditions. Because of the high prevalence of primary

school level respondents, the majority of those who did not improve their housing conditions were also primary school leavers.

The foregoing is evidenced by fewer respondents who had not improved their housing conditions. The study findings as shown by Table 18 strongly suggest basic capabilities were instrumental in enabling the respondents to the study to improve their housing conditions. 68.9 percent and 75 percent of those who said they improved their housing conditions in Buguruni and Vingunguti respectively also said they had attained human capability development to primary education level. Likewise, 25.8 percent and 22.22 percent of the study respondents from Buguruni and Vingunguti respectively who had improved their housing conditions said they had attained “other” education levels in the informal sector economy. The foregoing provides proof that attainment of basic capabilities among households contributes to capabilities to function in ways that improves their housing and from dominance basic capabilities attained in the form of primary education and “other” education.

Halla (1999) support this view and argues urban poverty is deprivations in basic functionings to improve housing conditions. He warns that limitations to access these basic capabilities leads to limitations to function in more complex ways such as the ability of the urban poor to improve their living standards, effectively participate in the urban formal economy, being able to match their skills and assets to existing urban opportunities, inability to transform their skills to improve their housing conditions, improvements of their health conditions, and to achieve higher functionings which enables them to achieve valued ends. Robeyns (2005) sums this-

up by stating evaluations and policies should focus on what people are able to do and be, on the quality of their life, and on removing obstacles in their lives so that they have more freedom to live the kind of life they have reason to value.

According to DCC (2009), the CIUP project also focused on human capability development since it built infrastructure that supported capabilities development such as education and health facilities. Other services which were supported included construction of social amenities such as clean water and sewage and solid waste disposal (DCC, 2009). The aim of the CIUP project was to make improvements of the physical infrastructure in urban informal settlements so the urban poor could have greater access to essential basic human development services (DCC, 2009). These services included improvements in education provision, water supply, waste water management, land-use planning, electricity supply, housing improvements, improvements in building inspection and improvements in health conditions among households though construction of health facilities in previously inaccessible informal settlement areas (DCC, 2009). These interventions were undertaken based on the premise that they had positive effects on reducing intra-city social inequalities in human capability development, as well as housing and health conditions among poor urban households.

4.3 Main Factors that Contributed to Failure of Households to Attain Some Elements of Human Capability Development

The study findings show lack of access to education, skills, credit and ownership of productive capital were the main factors that contributed to failure of some

households to attain human capability development to address their main housing and health problems as follows.

Table 19: Contributing Factors to Human Capabilities Development

FACTORS CONTRIBUTING TO ATTAINING OF BASIC CAPABILITIES	BASIC CAPABILITIES											
	Attained education (all levels)				Improved health conditions				Improved housing and shelter conditions			
	Buguruni		Vingunguti		Buguruni		Vingunguti		Buguruni		Vingunguti	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
credit accessed	8	16	10	20	5	29.1	2	41.7	6	90	5	100
Assets owned	6	8	19	14.1	1	2	5	10.2	2	37.5	7	55
Skills attained	8	38	10	26	5	37.5	2	41.7	4	41.7	2	50

Table 19 shows there were some capability elements which contributed more to development of basic capabilities compared to others. It can be seen for example, there was high proportion of the study respondents who accessed credit, and also said they improved their health conditions (29.1 percent in Buguruni and 41.7 percent in Vingunguti) and their shelter and housing conditions (90 percent in Buguruni and 100 percent in Vingunguti). This suggests access to credit was an important factor that contributes to attainment of human capabilities development.

The study respondents further said asset ownership contributed mostly to improvements in housing and shelter conditions followed by improvements in health conditions among households. Human capability development in skills possession appeared to be effective in developing basic capabilities across all levels. These levels included education attainment, as well as improvements in health and housing conditions. To this effect, 38 percent and 26 percent of respondents from Buguruni

and Vingunguti respectively who attained vocational skills also said they attained formal education. Likewise, the study respondents who possessed vocational skills also reported to have been able develop their human capabilities in improving their health conditions (37.5 percent and 41.7 percent in Buguruni and Vingunguti respectively) and improved their housing and shelter conditions (41.7 percent and 50 percent in Buguruni and Vingunguti respectively). These study findings show the study respondents who lacked human capability elements to access credit, own assets and possess vocational and trade skills also failed to attain basic human capabilities in education, improvement of health conditions and housing conditions.

Levels of income were also found to be another factor that contributed to failure of some households to attain basic human capacity development levels. Taking access to credit as an example of a main factor that contributes to attainment of human capability development, the study findings show, among the study respondents who accessed credit, the poor were least represented as shown by Table 20.

Table 20: Access to Credit by Expenditure Quintile

EXPENDITURE QUINTILE	ACCESS TO CREDIT							
	Buguruni				Vingunguti			
	ACCESSED		DID NOT ACCESS		ACCESSED		DID NOT ACCESS	
	No.	%	No.	%	No.	%	No.	%
Better-offs	2	41.7	3	58.3	2	50	1	50
Poor	4	17	22	83	6	19.5	25	80.5
Absolute poor	2	8.33	16	91.7	1	11.1	13	94.4
Extreme poor	0	0	1	100	1	50	1	50

It can be seen from Table 20 that generally, for all the case-study wards, the proportion of the study respondents who accessed credit was reducing by level of

income quintile. It can however equally be seen that there were higher proportions of the respondents to the study, across all quintile groups, who said they had not accessed credit. The proportion of the study respondents who said they did not access credit, with the exception between the absolute poor and extreme poor in Vingunguti, was increasing generally increasing from the better-off to the poorest. It can be seen that whereas 41.7 percent and 50 percent of the better-off respondents from Buguruni and Vingunguti accessed credit respectively, the proportions dropped to 17 percent (Buguruni) and 19.5 percent (Vingunguti) among the poor, 8.33 percent (Buguruni) and 13 percent (Vingunguti) for the absolute poor and none in Buguruni and 50 percent in Vingunguti.

The study went further to investigate who were the study respondents who had not access credit. The reason for undertaking this analysis was to find-out whether failure of some households to access credit was linked to failure of those households to attain basic capabilities in “other” education levels, which was being provided to households that were participating in the informal economy. This analysis showed Vingunguti, which was leading in the proportion of respondents who accessed credit, was also leading in the proportion of respondents that attained “other” education levels. 34 percent of respondents in Vingunguti attained “other” education compared to 24 percent in Buguruni. This translates to Vingunguti leading over Buguruni by 4.16 and 10 percentage points in access to credit and “other” education services respectively.

The study findings also showed lack of capital was another factor that contributed to failure of households to attain some elements of human capability development. 40

percent of respondents to the study for example mentioned lack of capital as a major reason why they could not use their current asset and skill base to improve their housing and health conditions. A further 20 percent of respondents mentioned low income as a main reason why the assets they owned were not used to minimize their housing and health problems. A further 40 percent of respondents said they did not even have assets that could be used to improve their housing and health conditions.

Whereas 12 percent of the study respondents from better-off households had attained secondary education, only 4.9 percent and 0.86 percent of respondents from middle-income and poor households said they had attained secondary education. This finding partly explains low levels of income, especially among poor households served as a barrier that causes lack of human capacity development in secondary education. This is underscored by the study findings shown by Table 13 (pp 98) which show there was a direct relationship between socio-economic background of respondents and attainment of secondary education.

This study finding is complemented by UNHABITAT (2010) who report there is strong association between lack of income opportunities and poor housing and health conditions between non-slum and slum urban areas. In the case of Asia, 17.9 percent of children in the main capital city of Nepal who lived in overcrowded urban informal settlements were exposed to diarrheal diseases due to lack of sanitation. This is compared to 12.6 percent in rural areas of Nepal and 10.3 percent of the country's other urban areas. Similarly, Simler and Dudwick (2010); UNHABITAT (2010) argue that even some parts of the United States cities exhibit sharp income

and non-income inequalities. Washington D.C. is a case in point where income inequalities is at a high gini-coefficient of 0.54; reflecting sharp social inequalities along wealth and race factors. As a result, there are significant, poor enclaves of African American and Hispanic minority communities concentrated in certain, unserviced parts of the city. In New Orleans on the other-hand, there are large pockets of populations that suffer from endemic poverty in the midst of wealthy populations. Overall, the United States of America has forty cities which have a gini-coefficient that is above 0.50, a level indicating high urban income inequalities. These inequalities are typically caused by poverty, racial segregation, post-industrial economic restructuring, the global economic meltdown, inner-city decline and development of sub-urban sprawl and ghetto-like housing conditions (UNHABITAT, 2010).

UCLAS and DHV (2004) report the situation is similar in urban informal settlements of Dar-es-Salaam. They state that few houses are connected to piped water. As a result, most houses use unhygienic shallow wells as a source of water for bathing, washing clothes and other forms of cleaningness. Drinking water is purchased through water vendors (UCLAS and DHV, 2004: 5).

As it has been mentioned at the beginning of this sub-section, lack of attainment of “other” education levels serves as another factor for failure to develop human capabilities among households. The study findings have shown lack of trade and vocational skills contributed to lack of capability development in terms of assets and income to enable the study respondents to improve their health and housing

conditions. Table 8 above, 37.5 percent of the study respondents from Vingunguti had vocational skills compared to 33.86 percent in Buguruni. This is also consistent with other types of human capabilities such as “other” education (34 percent in Vingunguti and 24 percent in Buguruni), access to credit services (19.7 percent in Vingunguti and 15.54 percent in Buguruni) and accumulation of productive assets (39.33 in Vingunguti and 12 percent in Buguruni). Table 21 presents a distribution of capabilities built by type of occupation, which also signifies extent of operating in the informal market economy.

Table 21: Level of Capability Attained by Occupational Category

HUMAN CAPABILITIES	FORMAL-EMPLOYMENT				SELF-EMPLOYMENT				SMALL BUSINESSES			
	BUGURUNI		VINGUNGUTI		BUGURUNI		VINGUNGUTI		BUGURUNI		VINGUNGUTI	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Better-off	0	0	2	12.9	1	12.5	1	3.33	2	10.8	1	4.2
Poor	7	50	5	30.3	7	87.5	16	68.9	13	69.3	8	56.7
Absolute poor	4	44.4	10	56.82	0	0	5	21.1	4	19.9	8	39.1
Extreme poor	1	5.5	0	0	0	0	2	6.7	0	0	0	0
Owned a shop	0	0	1	12.5	2	12.9	0	0	2	10.8	1	4.2
Owned land	0	0	0	0	0	0	3	18.7	0	0	5	20.8
Had “other” assets	0	0	1	12.5	0	0	1	6.25	0	0	5	26.7
Had no assets	11	94.4	5	62.5	15	87.1	19	75	17	89.2	6	48.3

Prior to discussing the foregoing Table, it is important to note that self-employment and operation of small businesses correlates with operating in the informal sector economy. Having said so, it can be seen that operating in the informal sector economy had strong correlation with human capability development among households. It can be seen from Table 21, for example, there were higher proportions of the poor among the self employed (87.5 percent in Buguruni and 68.9 percent in

Vingunguti) and owners of small businesses in the informal economy (69.3 percent in Buguruni and 56.7 in Vingunguti) compared to respondents who said they are formally employed in the informal sector (50 percent in Buguruni and 30.3 percent in Vingunguti). The pattern is generally the same, with lower proportions of extreme poor residents in the 3rd expenditure quintile among respondents who said their occupation is self-employed and/or owners of small business in the informal economy). Self-employment and small business ownership, especially with respect to low income groups, strongly correlates with participation of poor residents in the informal sector economy.

The findings of the study shown by Table 21 therefore show the level of informality of a settlement and the level of integration of households to the informal economy contributes to the human capacity development of households. Although ownership of a small shop and/or kiosks is evenly distributed across all occupational categories, ownership of "other" assets by the formally employed, self-employed and owners of shops/kiosk were exclusively owned in Vingunguti. Given a bigger presence of the informal market in Vingunguti, this again serves as testimony that the level of integration of households in the informal market contribute to human capability development among households. 12.5 percent of respondents who said they are formally employed in Vingunguti also said they own other assets.

This was also reflected by 6.5 percent of respondents who said they were self-employed and 26.7 owners of small shops/kiosks in Vingunguti. This is compared to none among these occupational categories in Buguruni.

4.4 The Extent to Which the Human Capability Attained by Households are Responsible for Reducing Problems of Poverty of Housing and Health Among Households

It was already explained under section 4.2 (pp 86) of this chapter that basic capabilities comprise education, health conditions and housing and shelter conditions. It can further be seen from the study findings as shown by Table 22 below that respondents to the study, without specifying which aspects, that the human capability development that they had acquired was instrumental in enabling them to reduce problems of poverty in dimensions of housing and health conditions as follows:

Table 22: Transformation of Human Capabilities Attained to Reduce Poverty in Housing and Health

Type of poverty reduced	Buguruni		Vingunguti	
	No.	%	No.	%
Housing problems	32	77.39	25	90.6
Health problems	6	14.76	5	18.40

Table 22 shows respondents to the study used their human capabilities to reduce their problems of poverty in housing and health conditions. An important observation to be made here is most respondents of the study used the human capabilities that they had attained to reduce their housing problems compared to their health conditions. Likewise, 14.76 and 18.40 of the study respondents from Buguruni and Vingunguti respectively said they had improved their health conditions. An explanation for this difference in-favour of Vingunguti can be found from the study findings which have

been already presented by Table 18 (pp 123) on Contributing Factors to Human Capabilities Development. The findings show the study respondents from Vingunguti who had accessed credit and who had obtained vocational skills had proportionally shown higher ability to reduce their problems in health compared to respondents from Buguruni. 41.7 percent of the study respondents from Vingunguti who had accessed credit and 41.7 percent who had attained vocational skills said, for example, they had improved their health problems.

Regarding housing and shelter conditions, it can be seen from Table 18 (pp 123) above that 68.9 percent and 75 percent of the study respondents who had attained primary education from Buguruni and Vingunguti respectively said they had used their human capacity development to improve their housing and shelter conditions. Overall, 25.8 percent and 22.22 percent from Buguruni and Vinguguti respectively said they had improved their housing conditions. Combined, the foregoing findings provide evidence that households in the case-study areas were using human capabilities attained to improve their housing conditions.

The linkage between health and housing conditions can be seen from the study findings that show 55 percent of respondents who owned assets in Vingunguti also said they had managed to improve their housing conditions compared to 37.5 percent in Buguruni. Furthermore; overall, Table 22 shows 90.6 percent of respondents from Vingunguti said they had used their assets and skills to improve their housing conditions. This is compared to 77.39 percent of the respondents from Buguruni. The study also finds higher levels of integration into the informal market economy that have been extensively presented and discussed under Section 4.2 (pp 86) above

explain these differences. Another reason to explain why the study respondents from Vingunguti, invested more of their acquired human capabilities to improve housing conditions is that respondents from Vingunguti were likely to have built their houses in the post-adjustment period and/or are still continuing to finish them. This is because Vingunguti received more new, informal housing development in the post-adjustment period.

The study findings also show respondents to the study made improvements to their housing conditions in small ways. This is evidenced by the study findings shown by Table 23.

Table 23: Level of Improvements in Housing Conditions

	IMPROVEMENTS IN HOUSING CONDITIONS	
LEVEL OF IMPROVEMENT	**No.**	**%**
Roof	18	14.8
Wall	7	13.46
Floor	4	11.11

The foregoing Table shows 23 percent of the respondents to the study had made improvements on the roofs of the houses. This is followed by 13.46 percent and 11.11 percent of respondents who said they made improvements on the walls and floors of their houses respectively. Out of these 8.89 percent of the study respondents who made improvements to the floors of their houses were respondents from better-off households, compared to 54.4 percent the poor, 33.33 percent absolute poor expenditure quintile and 33.33 percent extreme poor households. Those who made

improvements on their roofs on the other hand were 11.11 percent from better-off households, 72.22 percent from the poor expenditure quintile, and 16.67 percent from the absolute poor expenditure quintile and none among respondents from extreme poor households. This information shows there were consistently less proportion of poorer respondents to the study who said could improve either the floors, walls and/or roofs of their houses. This shows income serves as a barrier to households to make improvements on housing and shelter conditions in the case-study areas.

This finding of the study is consistent with reports by UCLAS and DHV which stated 60 percent of houses built in Myamani *mtaa* in one of the case-study areas were permanent while 30 percent semi-permanent and 10 percent temporary (UCLAS and DHV, 2004: 12). The same authors established that there were also inequalities in sanitation facilities used. 2 percent of households had septic tanks. Other indicators were VIP latrines (12 percent), pit latrines (69 percent) and temporary or no latrine (17 percent) (UCLAS and DHV, 2004: 6). These differences are reflective of social inequalities in housing conditions. Kiduanga (2002) confirms this and says in Buguruni ward, 38 percent of houses had walls built of poles, mud and plastered cement and sand walls. 50.4 percent had earth floors while 40.6 percent cement floors. Many households occupying houses with earth floors reported to have several problems including dust that threatens their health (Kiduanga, 2002: 355). The relationship between low human capabilities and poor urban housing conditions is explained by Forbes and Lindfield (1997) who report about the internally displaced persons who arrived in cities such as Phnom Pehn settled in marginal urban

informal settlements characterized by poor housing conditions. About 25 percent of households among these “urban refugees” lived in one room structures often with more than one family in occupancy. Furthermore, they had no flush toilet facilities. 15 percent had open pit toilets and 60 percent of them were overflowing. Sharing toilet facilities between households was a common practice. 40 percent of water used for cooking and drinking was purchased. Only 30 percent of their water sources were from piped water that was supplied by the city. Instead, they had to rely on unsafe water sources. 12 percent of water used by displaced persons in Phnom Pehn were from wells and the rest rain water, the latter serving as an important source (Forbes and Lindfield, 1997).

Low human capability levels and income barriers served as an important determinant of urban poverty in dimensions of poor housing and health conditions. As shown by Table 23, income barriers that emanate from low capability levels had necessitated the study respondents to make small improvements of their housing and shelter conditions. This is a reflection of housing and shelter improvements in the space of capability deprivation.

4.5 Effectiveness of the Human Capability Attained by Households in Reducing Inequalities between Poor and Non-Poor Households in Housing and Health Status

This section provides an assessment of the extent to which human capabilities attained by household were effective in reducing observed inequalities between the poor and non-poor households. In-order to achieve this, the section also makes an

analysis of inequality trends, both with respect to income inequalities, inequalities between the case-study *mitaas* and inequalities within the case-study *mitaas*. This analysis was instrumental in analyzing trends within the case-study *mitaas*, and shed light on factors that contribute to some households to acquire certain human capability development elements and why others did not. As a first step towards this end, Table 24 presents the study findings on income inequality trends between the case-study *mitaas*.

Table 24: Inequalities Between Case-study Mitaas By Expenditure Quintile

Quintiles	**Wards**				**Mean**
	Buguruni		**Vingunguti**		
	Mnyamani	**Kisiwani**	**Mtambani**	**Kombo**	
Rich	0	0	0	0	0
Better-off	8	12	4	8	8
Poor	44	60	68	56	57
Absolute poor	48	24	20	36	32
Extreme poor	0	4	8	0	3

Table 24 shows there were persistent inequalities between and within the case-study areas. The findings show the study respondents from Mtambani *mtaa* were, for example, leading in the study respondents who were categorized as poor. 68 percent of the respondents from Mtambani said they were poor. This is against an overall mean of 57 percent for the case-study areas as a whole. The respondents from Kisiwani *mtaa* who were categorized as poor were also slightly above the case-study average at 60 percent. The proportion of the poor in Kombo and Myamani *mitaas* on the other hand were both below the case-study areas average at 56 percent and 44 percent respectively.

Table 24 further shows the study respondents from Myamani were leading in the proportion of the study respondents who were categorized as absolute poor. 48 percent of the study respondents from Myamani were categorized as absolute poor compared to the mean of 32 percent for the case-study areas as a whole. The corresponding figures for this consumption/expenditure quintile were 36 percent from Kombo, 24 percent Kisiwani and 20 percent Mtambani.

Although at lower proportions, Mtambani was leading with highest proportion of the extreme poor. 8 percent of the study respondents from Mtambani were categorized as extremely poor against a mean for 3 percent for the case-study areas as a whole. This was followed by 4 percent of the study respondents from Kisiwani and none from Myamani and Kombo.

The categorization criteria for the extreme poor were those who said their expenditure levels were between TShs 1,000-1,500 per person per day per households. Given the fact that NBS (2009) calculated the cost of the food basket to be TShs 640.75 per adult equivalent, this means respondents from the above-mentioned extreme poor households in Mtambani and Kisiwani did not have the basic capabilities to purchase food at household level. In short, the afore-mentioned extreme poor households in Mtambani and Kisiwani were food poor. These respondents represents households which can be defined as extremely poor, and represent the long-term poor. One of the characteristics of long-term poverty is lack of possession of households to posses the basic capabilities to develop themselves, and as a result to reduce inequalities between the poor and non-poor in housing and

health status. This finding therefore tells us inequalities in income were one of the main factors behind making poor households less effective in reducing inequalities between the poor and non-poor in the case-study areas.

A closer scrutiny of the study findings shows social inequalities were more pronounced in Kisiwani followed by Mtambani, however generalized poverty was more predominant in Myamani and Kombo. It can be seen from Table 23 that, in Kisiwani, for example, 12 percent of the study respondents were categorized as better-off while 60 percent poor, 24 percent absolute poor and 4 percent extreme poor. In Mtambani, 8 percent of the study respondents said they were better-off, 56 percent poor, 20 percent absolute poor and 8 percent extreme poor. These findings show there was wide variation of income levels among the study respondents in Kisiwani and Mtambani. This is *de-facto*, what income inequalities are. The study findings show however the case was different for Myamani and Kombo *mitaas*. In these areas, poverty was generalised with 24 percent and 48 percent of the study respondents being absolute poor, although none were extreme poor.

As an indication that income inequalities breed extreme poverty, it can be seen that the small proportion of the extreme poor were found in Kisiwani and Mtambani *mitaas,* which did not only have high income distribution within the *mtaas*, but were also the only *mitaas* which had the extreme poor at 4 percent and 8 percent of the respondents respectively. Overall, the case-study findings shown by Table 24 above presents proof that there were high income inequalities both between and within the case-study *mitaas,* and that these inequalities reflect underlying inequalities in

attainment of human capabilities development between poor and non-poor households.

Table 25 presents the study findings on inequalities in various key human capability elements between poor and non-poor households in the case-study areas.

Table 25: Inequalities in Attainment of Human Capability Elements Between Poor and Non-Poor Households in Percentage

Level	**Buguruni**				**Vingunguti**			
	No.	Poor	No.	Non-poor	No.	Poor	No.	Non-poor
Secondary education achieved	3	7.14	1	16.66	0	0	4	25.49
"Other" levels of education achieved	6	25.37	6	33.33	4	31.11	13	43.27
Ownership of a productive asset – shop/kiosk/ business premises/small tool/equipment	3	7.39	5	10	3	7.13	3	6.2
Ownership of a productive asset – Land	0	0	0	0	1	5.5	9	19.6
Ownership of other assets	0	0	1	2	0	0	7	15
Did not have any productive assets	18	39.75	44	88	9	66.7	29	93.75

As an overview, it can be seen from Table 25 that there were also inequalities in attainment of human capability development between the case-study *mitaas*. A close scrutiny of Table 25 shows inequalities between the poor and non-poor in attainment of secondary education were highest in Vingunguti. While 25.49 percent of the non-poor in the *mtaa* attained secondary education, non-attained secondary education among the poor. This underscores an earlier observation made under Table 14 (pp 106) and Table 18 (pp 123) that there was less proportion of the study respondents

from Vingunguti who said they attained secondary education, and that lack of income was cited as a barrier. It can now be seen the poverty was a factor that hindered the attainment of secondary education in Vingunguti. It can further be seen that the non-poor were also leading among the study respondents who said they had attained "other" education levels, but there were less inequalities in attainment of this dimension of human capability at both *mitaa* level and between socio-economic backgrounds.

The findings of the study show participation in the informal sector market economy was an important factor that enabled poor families to attain capabilities and reduce inequalities between poor and non-poor households in the case-study areas. The study findings show, for example, there were sharp divisions in ownership of productive assets such as ownership of a shop/kiosk/business premises/small tool/equipment. Table 25 provide evidence that shows the poor had, although to a less extent when compared to the non-poor with respect to Buguruni, been able to develop their capabilities in ownership of productive assets. 7.13 percent and 7.39 percent of the poor in Vingunguti and Buguruni respectively said they had been able to attain productive assets. In fact, in Vingunguti, there were higher proportions of the poor who said they owned productive assets (7.13 percent) compared to the non-poor (6.2 percent).

The study findings also show that there were inequalities in other important assets such as land ownership and access to credit. The findings show land ownership was generally in favour of the non-poor in Vingunguti. Land ownership has high

influence on ownership of other assets and access to credit. Inequalities in land ownership therefore meant inequalities in other elements of human capability development, such as access to credit and "other" assets. As it can be seen on Table 24 (pp 138) there were sharp inequalities in ownership of "other" assets where none of the study respondents who were categorized as poor in both Buguruni and Vingunguti said they owned "other" assets. Likewise, Table 20 (pp 127) on Access to Credit by Expenditure Quintile above showed proportions of the study respondents who said they accessed credit was declining from those who said they came from better-off to poorer households. The effects of exclusion of the poor from access to credit need to be underscored. Table 19 (pp 126) above on Contributing Factors to Human Capabilities Development showed, for example, 90 percent and 100 percent of the study respondents from Buguruni and Vingunguti respectively who had improved their housing and health conditions had also said they had accessed credit. This argument is taken further by the study findings that provide a summary of inequality levels in credit accessed and in modalities which assets were obtained as shown by Table 26.

Table 26 shows the main channel that was used by the study respondents to attain assets was through doing small business, accessing credit and saving from formal employment. All respondents from Myamani for example said they had attained their assets from doing small businesses. The sources of capabilities to possess assets were diverse in other case-study *mitaas.* Kombo, for example, had the most diverse sources ranging from 30.77 percent of the study respondents who said they had acquired assets through doing small businesses, 15.38 through credit, 15.38 through

savings from formal employment and 7.69 through selling other assets. This shows there were many channels that the study respondents used to acquire assets. No doubt the sale of current assets to acquire new assets, which was reported in Mtambani (25 percent) and Kombo (7.69 percent), reflects extreme poverty.

Table 26: Inequalities in Attainment of Assets and Credit in Case-study Mitaas

Variable	Mnyamani	Kisiwani	Mtambani	Kombo	Mean
How asset owned were obtained					
From doing small business	100	16.67	25	30.77	43.11
Savings from formal employment	-	-	25	15.38	10.09
Sold other assets	-	-	25	7.69	8.17
Through remittances/grant from family members	-	16.67	-	-	4.17
Inherited	-	16.67	-	-	4.17
Through credit	-	50	25	15.38	22.59
Amount of credit accessed					
50,000-100,000	16.67	50	75	16.67	39.58
100,001- 150,000	-	-	-	16.67	4.17
150,001-200,000	33.34	-	25	-	14.58
200,001-250,000	-	-	-	33.33	8.33
250,001-300,000	33.34	-	-	-	8.33
300,000 and above	-	50	-	33.33	20.83

It is further noted from Table 26 that there were inequalities in the levels of credit that were accessed by respondents from the different case-study *mitaas*. This validates the study findings which were already presented by Table 20 (pp 127) on Access to Credit by Expenditure Quintile above. The study findings show there were fewer inequalities in access to different levels of credit from respondents in Kombo

and Myamani compared to Kisiwani and Mtambani. This can largely be explained by the fact that Kombo and Myamani were areas that the informal sector market and trading was more prevalent, and therefore easier to access credit. Mtambani, which was also an area where informal trading activities were pronounced, shows weaker capabilities in access to assets and credit where multiple channels were used including selling assets and saving from employment, indicating vulnerability, and, as an indication of lower capabilities, higher proportions of those who accessed small amounts of credit. These shows there were informal sector activities in Mtambani but under the conditions of low human capability development levels. Table 27 below presents the distribution of the study respondents who said they were undertaking self-employment and small businesses, which connotes level of informal sector economy development, in the case-study *mitaas.*

Table 27: Proportion of the Study Respondents who Undertake Self-Employment and Small Businesses in the Informal Sector in Case-study Mitaas

SELF-EMPLOYMENT								**SMALL BUSINESSES**							
MYAMANI		**KISIWANI**		**MTAMBANI**		**KOMBO**		**MYAMANI**		**KISIWANI**		**MTAMBANI**		**KOMBO**	
No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
11	44	6	24	15	60	9	36	11	44	8	32	5	20	12	48

It can be seen from Table 27, the highest proportion of the study respondents who said they owned small businesses were from Kombo, followed by Myamani. Likewise, those who said they were self-employed were mainly located in informal market areas of Mtambani and Myamani, indicating informal sector economy activities were more pronounced in these *mitaas*.

Furthermore, Table 26 (144) above on Inequalities in Attainment of Assets and Credit in Case-study *Mitaas* shows Mtambani and Kombo were the worst-off in-terms of lacking human capability elements to improve their housing and health status. Their lack of human capability elements was expressly manifested in lack of assets and opportunities to acquire those assets. 25 percent and 7.69 percent of Mtambani and Kombo residents for example said they had no other means available to them to purchase their main current productive asset, such that they had to sell some of their existing assets. This indicates this segment of residents in the case-study areas was severely deprived in the space of capabilities to attain productive assets. This is because they did not have savings from either formal employment and/or small businesses, nor did they belong to any informal social networks. As a result, they could not get remittances, grant or income from inheritance or access credit. They were therefore left with no recourse but to sell their assets, which contributed to further deprivation of capabilities. This information confirms that there were sharp inequalities in human capability levels to acquire and own productive assets in the case-study areas, with Mtambani and Kombo being most deprived in asset acquisition capabilities.

The extent to which human capabilities to access credit, and to access higher amounts of credit determines the effectiveness in which households can use their human capabilities to transform skills and assets into income so that they can be used to reduce their poverty in housing and health. As it can be seen from the same Table 26 (pp 144) above, there was high inequalities between the poor and non-poor in the amount of credit that households in the case-study *mitaas* were able to access. There

are some households that accessed very small amounts of credit (TShs 50,000 - 100,000), small amount (TShs 100,001-150,000) medium (TShs 150,001-300,000) and large credit (TShs 300,000 and above). Beginning with very small credit, it can be seen that the majority of Mtambani and Kisiwani residents accessed this type of credit facility. 75 percent and 50 percent of respondents in Mtambani and Kisiwani *"mitaas"* accessed very small loans (micro-credit) compared to the mean of 39.58 percent across the case-study areas. The households in the case-study *"mitaas"* accessed small credit amounts and used this human capability element attained to reduce inequalities with the non-poor in housing and health status. This is a larger proportion compared to Myamani and Kombo residents where only 16.67 percent of the residents said they received very small credit of between TShs 50,000 – 100,000. Inequalities between households in access to credit were revealed by the study findings which showed Kombo residents accessed similar but slightly higher credit services. 16.67 percent of Kombo residents received small loans of between TShs 100,001-150,000.

The implications of high inequalities in welfare distribution within cities were acknowledged by Halla (1999). He noted that, because of inherent inequalities, high economic growth alone in cities cannot guarantee higher living standards. He goes-on to argue for economic growth to be converted to observable social welfare, other conditions are necessary. He mentions these as appropriate political and governance structures (Halla, 1999: 23). According to Nondo and Coetzee (2002), urban inequality levels are often obscured by the fact that deep and persistent poverty often exists in urban settlements in the outskirts of cities.

Overall, the study findings show very small amounts of loans were important to informal sector operators who used them to "enlarge their opportunities" to function in different ways which they could previously not (Sen, 1999). Human capabilities obtained from access to credit was generally effective in reducing inequalities between the poor and non-poor by increasing capabilities of poor households to integrate into the informal and eventually the mainstream urban economy, and to function in many different ways that they have reason to value (Kweka and Fox, 2011). These are the type of traders, usually characteristic of long-term urban residents, who access very small loans to finance domestic enterprises. Myamani and Kombo on the other hand dominated as *"mitaas"* which accessed medium-size loans. 66.68 percent and 33.33 percent of residents in Myamani and Kombo accessed medium-size loans. The human capacity to access medium-size loans is a reflection of robustness of the main economic activity of residents in a particular case-study *"mtaa."* Myamani and Kombo residents were able to access medium-sized credit because of their connection to Myamani market, which is the main commercial hub of the case-study areas. As it has already been mentioned above, Kombo residents also conduct their business activities in Myamani.

Access to large loans is indicative of households with sufficiently developed human capability elements to undertake activities that can be used to reduce their housing and health problems. The study findings show Kisiwani, which was mentioned above as a mixed *"mtaa"* of informal settlements and surveyed areas, and one with the highest proportion, 36 percent of formally employed, was also leading in the proportion of residents who accessed large loans (TShs 300,000 and above).

Whereas 50 percent of Kisiwani residents accessed very small loans and no medium loans, another 50 percent could access large loans. This paints a picture of Kisiwani as a *"mtaa"* with sharp levels of inequalities in human capability elements to access credit. In the case of Mtambani, although 75 percent of its residents accessed very small loans, there were 25 percent of households in the same *"mtaa"* who accessed medium-term loans. Human capabilities attained in access to credit has been more effective in reducing inequalities between the poor and non-poor in Mtambani, compared to Kisiwani since the former is composed by a mixture of long-term settlements with established households which are mainly doing very small, household based informal activities and others who have moved into the area and conduct small and medium-sized trade around Myamani market area. For the same reasons, Kombo is also a fairly mixed *"mtaa"* with equal proportions of households who have capacity to access very small, medium and large loans. As it can be seen, Myamani has also got a fairly equal distribution of households who accessed medium loans, but has also got its share of 16.67 percent of households who accessed very small loans.

The study findings have further shown that human development levels in "other" levels of education achieved, which include continuing education in the informal sector was an effective means that was available to poor households to attain capability development. Table 25 (pp 141) above on Inequalities in Attainment of Human Capability Elements between Poor and Non-Poor Households show there were low inequalities in achievement of post-primary education between the poor and non-poor in both the two case-study wards. 16.66 percent and 25.49 percent of

non-poor study respondents in Buguruni and Vingunguti said they achieved secondary education compared to 7.14 percent and none of poor respondents respectively.

It can further be seen from the same Table that 25.37 percent and 31.11 percent of the poor in Buguruni and Vingunguti wards had attained human capabilities development in “other” levels of education. This shows attainment of human capabilities, mainly through participation in the informal market economy, which was more pronounced in Vingunguti compared to Buguruni, was effective in increasing the proportion of the poor in achievement of “other” education levels, access to credit and ownership of other assets.

It can further be noted that the proportion of the non-poor who had “other” level of education achieved in Vingunguti was higher compared to the non-poor in Buguruni. This can be a result of the following two explanations. First, it could be a reflection of higher social inequalities within Vingunguti where the non-poor were more effective compared to the poor in attaining human capabilities development in “other” education levels achieved. Secondly, it could be a reflection of the effectiveness of “other” education levels achieved in reducing inequalities between the poor and non-poor in poverty housing and health status. This finding can be substantiated by the study findings presented by Table 22 (pp 133) on Transformation of Human Capabilities Attained to Reduce Poverty in Housing and Health that showed a higher proportion of respondents in Vingunguti said they were able to transform their assets and skills to reduce their housing and health problems

(90.6 percent and 18.40 percent respectively) compared to those from Buguruni (77.39 percent and 14.76 percent respectively). This finding suggests poor residents of Vingunguti who attained human capability in "other" education levels used it effectively to reduce their poverty in housing and health. The distribution of other human capabilities development achieved between the case-study *mitaas* is presented by Table 28.

Table 28: Inequality Levels in Housing and Health between the Case-study Mitaas

	Case-study Mtaa				
Basic Capability	**Mnyamani**	**Kisiwani**	**Mtambani**	**Kombo**	**Mean**
How main economic activity has helped reduced main housing and health problem					
Has helped in various small ways	10.53	9.09	-	6.25	6.47
Has not helped	31.58	13.64	-	18.75	15.99
Main barrier to reducing main housing and health problem					
Lack of skills	-	40	-	50	22.5
Low income	100	20	100	50	67.5
Lack of working capital	-	40	-	-	10
Built/improved house	57.89	77.27	100	75	77.54
Housing condition – number of people who sleep per room (room density)					
1-2 people per room	62.50	56	68	44	57.62
3-4 people per room	25	40	24	40	32.25
More than 4 people per room	12.50	4	8	16	10.12
Diseases that members of household frequently suffer from					
Malaria	68	64	80	84	74
Other diseases	28	36	8	8	20
Did not suffer from diseases	4	-	12	8	6

Table 28 shows inequalities in actual attainment of human capabilities between the case-study *mitaas*. The evidence from the study as shown by Table 28 shows some

households in the case-study *mitaas* were actually able to use human capabilities levels which they had achieved to reduce their problems in housing and health. As it can be seen, 10.53 percent of the study respondents from Myamani had, for example, said their main economic activity had helped them to make small improvements to reduce their housing and health problems. The corresponding figures were 9.09 percent in Kisiwani, and 6.25 percent in Kombo. Although none of the study respondents from Mtambani said their main economic activity had helped them to reduce their main problems in housing and health.

The importance of this information is it provides evidence that there was evidence some respondents from the study had made effective use of the human capabilities development, which were translated in their main economic activities to reduce their problems in housing and health. Some of the key factors responsible for making households to reduce their problems of housing and health have been presented by Tables in previous sections. Table 9 (pp 87) on Level of Human Capability Attained by Respondents in the Case-study Areas for example showed 67.6 percent and 87.5 percent of the study respondents from Buguruni and Vingunguti respectively said they had been able to build a house and 77.4 percent and 90.6 percent said had been able to reduce housing and shelter conditions respectively. Although to a lesser extent, the same Table 9 showed 14.8 percent and 18.4 percent of the study respondents had been able to take actions that minimized their health problems.

The study findings have provided evidence that human capabilities that were attained by households have indeed been effective in reducing poverty in housing and health

conditions. This premise is clearly substantiated by the study findings as shown by Table 28 above that show a proportionate mean of 77.54 percent of households in the case-study areas did actually manage to improve their housing and health problems. Cognisance is however taken on the significance of inequality levels within these gains. 15.99 percent of respondents said, for example, their main economic activities have not helped them to improve their housing and health problems while 6.47 percent said it helped in various small ways. The study findings show Mtambani was most successful (100 percent) in effectiveness of main economic activity to reduce inequalities between poor and non-poor households in housing status. This was closely followed by Kisiwani (77.27 percent) and Kombo (75 percent). Myamani was leading in both the proportion of households whose main economic activity has not reduced inequalities between the poor and non-poor in housing and health status and/or helped in various small ways.

This is an indication of high inequalities in housing and health conditions in Myamani. The corresponding figures are 18.75 percent and 6.25 percent in Kombo and 13.64 percent and 9.09 percent in Kisiwani. The factors that hinder effectiveness of human capabilities attained by the poor to reduce inequalities in relation to the non-poor in housing and health conditions can best be explained by underlying inequalities in availability of land to improve housing conditions. That if housing conditions are improved, then the hygiene and environmental public health conditions of households will also be improved. Myamani for example is a long-term settlement with lower average housing density. All residents of the *"mtaa"* who were interviewed as part of this study said they used human capability elements

attained from their main economic activities to improve their housing conditions. The rest of the case-study *"mitaas"* show more or less the same pattern where a majority have used their human capabilities elements attained from their main economic activity to improve their housing conditions followed by a significant proportion whose main economic activity did not help and about a tenth who have made small improvements.

Cognisance is taken on the fact that if households do not have land to improve their houses such as constructing a sewage disposal tank, then, even if they realize additional income, they can only make "various small improvements" or not make any improvements at all. Consequently, even if these households attain new human capability elements, they cannot be translated into improvement in their housing and health conditions. This, among other issues helps to explain the observed inequalities in improvement in housing (and health) conditions between Mtambani and Kombo on the one hand and Myamani and Kisiwani in the other.

Inequalities in housing conditions can also be measured in terms of inequalities in room density (i.e. number of people who sleep in the same room) among households. This is because households would have wanted to improve housing conditions in cases where they have high room density levels. High room density, which is also known as "overcrowding," is also associated with poor health conditions among households such as poor sanitation conditions since there will be high per capita use of toilets, and greater risks of health conditions such as tuberculosis, malaria, dysentery and upper respiratory tract infections. This points towards the fact that

inequalities in the level of planned settlements is associated with inequalities in household capacities to improve their housing and health conditions. The study findings shown by Table 27 above show Kombo is the case-study *"mtaa"* with the worst housing conditions with 40 percent of households with 3-4 people sleeping in the same room and 16 percent with more than 4 people sleeping in the same room. This condition is closely related to the problem of land scarcity, housing density along sloppy land leading to the Msimbazi river valley and a wave of new immigrants who moved into Kombo "mtaa" during the adjustment years of the 1990s. Kisiwani and Myamani follow in overcrowding finding show 40 percent of Kisiwani residents sleeping 3-4 persons per room while in Myamani, 12.5 percent sleep 4 persons or more per room.

This shows, apart from Kombo, the problems of poor housing conditions in the dimension of overcrowding also exists in Kisiwani, but exists in more extreme forms in Myamani, and extremely in Kombo. The data shows Mtambani does not face extreme forms of overcrowding although has low but proportionally more, 8 percent, of people who sleep 4 people and above in a room compared to Kisiwani which was 4 percent.

As already stated above, these inequalities in housing conditions contribute to poverty in health conditions among households. This is exemplified by the study findings shown on Table 28 above that show the majority of residents in the case-study areas, a proportionate mean of 74 percent, said they frequently suffered from malaria as a leading disease that affects their household members. Vingunguti ward

seem to proportionally be more affected with malaria compared to *"mitaas"* in Buguruni. 84 percent and 80 percent of households in Kombo and Mtambani respectively responded malaria was the leading disease that affects their households. This is compared to 68 percent and 64 percent of households in Myamani and Kisiwani respectively. An inverse pattern is however observed when it comes to "other" diseases. 36 percent of households in Kisiwani said their households frequently suffered from "other" diseases such as dysentery, diarrheal and upper respiratory track diseases. Although a small proportion, Mtambani was leading among households that did not frequently suffer from diseases. 8 percent of households in Mtambani responded they did not frequently suffer diseases compared to 8 percent in Kombo, 4 percent in Myamani and none in Kisiwani.

This data provides proof that inequalities in the way households are exposed to health risks in the case-study areas exist. Overall, the biggest health risk faced by households in the case-study areas is malaria. Since malaria is a vector borne disease, and these vectors breed in a polluted environment; high prevalence of malaria is an indication of poor housing and basic housing and shelter environment health conditions in the case-study areas. Other diseases such as dysentery, diarrheal and upper respiratory tract infections are also attributed to poor housing and environmental health. "Other" diseases which form the second most important health risks for households in the case-study areas is closely associated with poor housing conditions, open sewers, ponds, construction of housing in marshy and shrub lands, as well as high room density and overcrowding. The study finds households which attain human capabilities to reduce the afore-mentioned housing problems would

make the necessary investment to improve housing and shelter conditions in order to reduce their poverty housing and health conditions, and in the process contribute to reducing inequalities between poor and non-poor households in housing and health status. This explains why there are a minority of households, a mean of 6 percent of all households in the case-study areas who do not frequently experience health problems.

It can further be observed from Table 24 (pp 138) above that there were some well-off households, in the same area, which consumed TShs 5,001-10,000 per day. Kisiwani is leading under this category with 12 percent of households under this consumption/expenditure category. This is mainly reflecting its mixed income and partly surveyed nature. The same Table 24 shows there were better-off households in other case-study *mitaas* as well with Myamani and Kombo having a proportion of 8 percent of well-off households each. The *"mtaa"* with the least number of the better-offs is Mtambani (4 percent), again, reflecting its nature of a long-term indigenous settlement. Mtambani, which has the least proportion of better-off residents is also leading in the proportion of households in the third income quintile; and leading in the proportion of residents who were extreme poor (i.e. did not have sufficient income to purchase a meal).

Kisiwani on the other hand was leading in the proportion of residents who are better-off, second to Mtambani in the proportion of households who were poor; but has higher proportion of the absolute poor, and has also got 4 percent of households who were extreme poor. Myamani and Kombo were a bit more egalitarian. Slightly more

than half, 56 percent, of residents in Kombo were poor, and larger proportion, 36 percent of the absolute poor compared to Kisiwani (24 percent) and Mtambani (20 percent). No household that participated in the study was categorized as extreme poor in Kombo. Myamani is the most egalitarian with a proportion of 92 of its residents categorized as poor and absolute poor, and 8 percent under the better-off category, against the mean of 8 percent, therefore making it proportional to the case-study areas average for better-off households.

The study ends this analysis by recognizing better-off households had been an effective role in providing opportunities to poor households to attain human capabilities which are then used to reduce inequalities between poor and non-poor households in housing and health status. Arguably, although a minority (proportionate mean of only 8 percent across the case-study areas), better-off households spent between TShs 5,000-10,000 a day, helping to stimulate the economy by creating effective demand for services which are provided by the poor such as purchase of charcoal, supply of kerosene, masonry, carpentry-work, purchase of food and clothing and related matters.

These skills and services correspond to those which were earlier mentioned to have contributed to effectiveness of human capability elements attained by households in reducing inequalities between poor and non-poor households in housing and health status. Despite observed inequality levels, better-off households played a critical role in stimulating the urban economy, thus enabling the absolute poor and extreme poor quintiles to earn income, exercise and improve their skills; be able to access credit

(because of prospects of returns from their investments towards providing services to non-poor households), acquire main productive assets, in the process, acquiring human capabilities to improve their housing conditions and reduce their health problems.

CHAPTER FIVE

5.0 SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This Chapter presents a summary, then followed by conclusion and recommendations of the study. The summary provides a brief account of the main thrust of the study from across all sections of the study. The conclusion on the other hand emphasizes and provides some additional thoughts on the central argument of the study. The study ends by providing some recommendations which present possible areas for policy application and suggestions for future research.

5.2 Summary of the Study

5.2.1 General Summary

The study has investigated the interrelationship between three variables that define urban poverty. These variables include social inequalities in human capability developments attained, housing, and health conditions among poor urban households.

The study established that urban poverty is rapidly and exponentially increasing. It further established that the world population will be, for the first time ever, 50 percent urban by 2050. An investigative analysis that was conducted at the beginning of this study on the background to the problem of urban poverty in Tanzania showed rapid urban development through internal increase and rural to urban migration in Tanzania has resulted in sub-standard housing and shelter development, which has

resulted in an increase in unserviced settlements. A review of literature concerning urbanization in LDCs and other regions of the world revealed urbanisation, particularly in LDCs like Tanzania, is unsustainable. The reason behind this was such urbanisation is taking place under conditions of poverty and capability deprivations. As a result, urbanization in LDCs is experiencing low human capability development levels to improve urban housing and health conditions.

The study undertook a comparative review of urbanization in different parts of the world and Tanzania. The review has shown urban poverty is most expressly manifested by social inequalities in housing and shelter conditions. Ultimately, these conditions manifest themselves in poor housing and health conditions among the urban poor. Consequently, in the extreme, urbanising under conditions of poverty and capability deprivations has been the main driving force of development of urban sprawls, unserviced settlements and the world's slums. The latter is characterized by extreme conditions of urban poverty as expressed by poor housing and health conditions.

Empirical findings of the study showed income poverty among the urban poor in the case-study areas contributed to deprivations in capabilities, notably in attainment of post-secondary education, access to credit, attainment of vocational skills and productive assets. Evidence from the field showed capability deprivations in all of the foregoing areas contributed to poor households being less effective in transforming their skills and assets into improvements of their housing and health conditions. This being said, the study findings showed such capability deprivations

were in no way universal in poor urban settlements. Empirical evidence from the study showed there were some residents of the case-study areas who reported to have had improved their housing and health conditions. This indicates the problem of sustainable urbanization does not lie in the workings of the urban economy, but in social inequalities in the distribution of capabilities

5.2.2 Summary of Key Findings of the Study

The following sub-sections provide summary of key findings of the study.

5.2.2.1 Levels of Human Capabilities in the Case-Study Areas

Using the basic needs approach, the study established they were some households that managed to develop human capabilities in the case-study areas. The basic needs approach measures poverty in multidimensional terms. The approach employs three dimensions namely education, health (including water and sanitation) and housing and shelter conditions. Access to education and health account for human capital to function in ways that can improve living conditions.

The findings showed human capabilities in achievement of primary education and building houses to reduce shelter and housing conditions were the most achieved. Although to a smaller extent, but capabilities to access vocational skills and “other” continuing education were significant. They were also found to be significant in enabling the study respondents to acquire productive capabilities (access credit, own assets and to enhance effectiveness of main economic activity to reduce housing and health problem).

In comparison, there were lower levels in human capabilities achieved to reduce health problems. The findings show there were social inequalities in achievement of human capability levels. Achievement of some human capability levels (primary, vocational, “other” continuing education, build houses and reduce shelter conditions) were more widespread than others (reduce health problems, and access to secondary, and adult education).

5.2.2.2 Factors that Affect Households to Attain Human Capability Elements

The findings of the study showed levels of income were main barriers to attain human capabilities. The findings showed the majority of the study respondents were poor followed by the absolute poor (together accounting for 89 percent of the respondents). The income levels of the poor were not sufficient to reduce their housing and health problems. As a result, improvements in housing were typically done in bits and pieces. Some respondents had only capabilities to improve their roofs and walls, while less could improve floors.

The study findings showed access to credit, productive assets, vocational skills, primary and post-primary education enhanced human capabilities of the study respondents to improve their housing and health conditions.

5.2.2.3 Extent to which Human Capability Elements had Impact on Reducing Poverty in Housing and Health

The study findings validated urban poverty is expressly manifested in poor housing and health conditions. The finding has further shown income served as an important barrier to reduction of poverty in housing and health. It further emerged that an

important element for impact on poverty were capabilities of households to acquire elements that would enable their main economic activity to transform household asset base to income and consumption to reduce their problems in housing and health conditions.

Again, as in the preceding findings, the study findings showed access to education, vocational skills, credit services, productive assets were instrumental to impact on urban poverty. These elements were generally more effective in reducing poverty in housing compared to health conditions.

5.3 Conclusions

This section presents the main conclusions of the study. The conclusions are aligned to the specific objectives of the study as stated under section 1.2.1 (pp 15) of this study.

A main conclusion drawn from the findings of the study is that social inequalities exist in urban informal settlements such as the case-study areas. These inequalities are reflective of prevalent low human capability levels among the urban poor. Consequently, high prevalence of low human capabilities affect capabilities of households in poor urban informal settlements to improve their housing and health conditions. As a result, urban poverty is expressly manifested in social inequalities in poor housing and health conditions among households.

The study has further validated the interrelationship between social inequalities (in human capacity development), poor housing, and health conditions as determinants

of urban poverty. The study concludes lack of key human capability elements is a key factor in reducing effectiveness of households to reduce their housing and health problems. These human capability elements include access to capabilities such as formal education, vocational skills, continuing education, “other” education-levels, credit services and productive assets. The study concludes that households that acquired these elements were effective in reducing their housing and health conditions.

A cross-examination of the study findings on household income levels, and housing and health conditions had generally showed the study respondents who reported to be living in poor housing conditions and health conditions. The study concludes that poor housing conditions such as overcrowding, unfinished houses and poor sanitation have adverse effects on health conditions among households in urban informal settlements. The health conditions malaria and “other” diseases (including diarrhea, cholera, TB, dysentery and others).

The study concludes the relevance of household incomes in human capability development as clearly supported by the study findings. As such, the study concludes there is a vicious cycle between low-levels of incomes in urban informal settlements and human capability development. As a result, poor urban households are held under a capability deprivation trap. They cannot raise sufficient household incomes to reduce their housing and health problems. The study notes this is primarily because their current human capability development levels are not sufficient to enable them to obtain sufficient income to reduce their housing and health problems.

The study concludes urban poverty reduction can therefore be best understood through addressing social inequalities in human capability development. It further concludes this can be done by integrating inequality sensitivity analysis in urban poverty reduction strategies such as the PRS, MKUKUTA and MKUKUTA II.

Although the list is not conclusive, the study concludes the following key areas to be considered in urban poverty reduction policies. These areas are investing in basic, secondary and vocational education, enlargement of access to credit, increase in direct participation in the mainstream urban economy, access to assets and social protection against cyclic vulnerabilities that are brought about by adjustment measures. The study concludes the latter is important to protect and repair capabilities which have already been attained. This is because the study showed the urban poor who participated in the study had lost assets, including land and other productive assets during adjustment.

Lastly, the study concludes the findings of the study have made a noteworthy contribution by showing the importance of attainment of basic capabilities and the potential of households in urban areas to make their own improvements in their housing and health conditions. This conclusion is evidenced by some respondents who said they have improved their housing conditions, and as a result they were not frequent victims of poor health conditions. This was collaborated by observation studies which showed there were some houses with highly improved conditions including own water and sanitation infrastructure or systems shared between two or three better-off households.

These improvements further contributed to reduction of community health households with improved housing conditions did not release solid waste including sewerage into furrows, waterways, open sewers and/or streets. The study concludes that if inequalities in basic human capability development between the poor and non-poor were reduced, then urban households and communities more generally would be more effective in functioning in ways that reduce their poverty in housing and health conditions. The contrary would be a continuation of current conditions of urbanizing under conditions of poverty which is characterized by an urban sprawl with poor and sub-standard housing and shelter conditions, make-shift houses, unserviced settlements and slum-like conditions with poor housing conditions.

The study concludes that the findings were inventive. In contrast to what has been widely practiced by public policy in Tanzania (the PRS/MKUKUTA I and MKUKUTA II), the study has successful portrayed urban poverty as a function of capability deprivations. The study concludes that conceptualising urban poverty as such involves understanding urban poverty in two main ways.

First, as a function of insufficient levels of public investments which are being overstretched by rapid urban population growth. Secondly, as inequalities in capabilities that underlies the problem of urban poverty. Based on this, the study concludes it is now possible to state that human capability development attained by households have a significant role in reducing the problems of poverty of housing and health afflicting urban households, and that they are effective in reducing inequality levels between poor and non-poor households in urban housing and health status.

5.4 Recommendations of the Study

5.4.1 This Section Presents Recommendations from the Main Findings of the Study. Factor in Inequality Analysis in Development of Urban Poverty Strategies

The study findings have added substantially to our understanding of social inequalities in capability development and how they affect the urban poor to improve their housing and health conditions. The background analysis of the study had, however, shown that urban poverty strategies in Tanzania, namely the PRS, MKUKUTA I and MKUKUTA II did not decomposed data to show inequalities between the poor and non-poor when making an assessment of urban poverty and capability development. As a result, the afore-mentioned studies show cities such as Dar-es-Salaam and other cities of Tanzania were on course of meeting millennium development targets of halving poverty between 1990 and 2015.

The study recommends, given the high density and sharper income disparities in urban areas, urban anti-poverty estimates should be decomposed to ward-level. This measure will assist in more robust analysis of urban poverty profiles and improved targeting by urban poverty strategies.

5.4.2 Integrate Capability Analysis in Urban Policy and Planning

The current study has shown poverty can be understood differently from a capability approach. That poverty is not only a function of short-falls in consumption and/or basic needs, but that it is, essentially, a reflection of capability deprivations. In this context, social inequalities continue to widen as the non-poor with sufficiently human capacity development tend to be more effective their basic needs compared to

the non-poor. The study recommends a review of the current MKUKUTA II should factor-in a stronger focus on human capability development, which the current version, which focused on strategies to maintain a certain threshold of utility consumption at the household level, does not have.

In pursuing a capability orientation, the MKUKUTA review should seek to develop strategies to build basic capabilities among the urban poor. These include improving access to food, basic education and vocational skills, and access to health services. The study findings have shown, based on analysis of effectiveness of current non-poor households in improving their housing conditions, these will translate in improvements of housing and shelter conditions among the urban poor.

5.4.3 Enhance Informal Sector Development Policies to Strengthen Basic Capabilities of the Urban Poor

The findings of this study have shown participation in the informal sector led to enlargement of the urban poor in-terms of access to credit, productive assets and vocational skills, thus making them effective in transforming their asset and skill base to improvements in their housing and health conditions. The study notes on the other hand, Government policy towards informal sector traders has been restrictive.

First, informal operators were being denied licenses to operate. Second, where they were allowed to operate there were restrictive tax regimes. Third, Government efforts through the MKURABITA informal property formalization programme, which forms part of the MKURABITA aims at accelerating informal operators to graduate to formal operators. The study recommends the MKUKUTA and MKURABITA mechanism to introduce further de-regulation of the informal sector

market. Municipal regulations should be changed to remove unnecessary barriers to free participation of the urban poor in the informal sector economy.

5.4.4 MKUKUTA II Needs to Provide Increased Attention to Credit Services that help the Urban Poor to Acquire Productive Assets

The study recommends scaling-up of credit services to poor households in the urban informal sector. This recommendation is based on the study findings that showed access to credit was a key factor that allowed households to access productive assets and to participate in the informal sector economy. In-turn, these made households effective in improving their housing and health conditions. The Government, in the context of MKUKUTA has already got several micro-finance schemes including SELF II programme and the Small Industries Development Organisation (SIDO).

One weakness of these is they area disproportionally geared towards supporting rural agricultural transformation. This study recommends these programmes should orient and scale-up their urban components. This measure will be effective in reducing urban poverty in dimensions of health, housing and shelter conditions.

5.4.5 Policy Measures to Improve Vocational Training Skills Provide an Effective Measure for Helping Poor Urban Households to Acquire Human Capacity Development and to improve their Housing and Health Conditions

The study findings have shown low levels of education levels attained among households in the case-study areas as one of the main inhibiting factors to human capacity development and to the ability of the urban poor to transform their skills, assets and capital to improve their housing and health conditions. The study

recommends the MKUKUTA II and other policy interventions on urban poverty to intensify education provision in the case-study areas, particularly focusing on education provision in informal unserviced settlements, as well as provision of post-primary education (i.e. secondary education and vocational training).

The study finds such an approach will contribute positively to developing the foundations of human capacity development levels of the poor and enable residents of the study area to acquire skills and education levels through continuing education that is being provided by NGOs and the municipal government. The provision of education is an entitlement that will widen choices that the urban poor can make to engage in income generation activities and to improve their living conditions in the post-adjustment market economy.

One of the measures taken by the PRS and MKUKUTA is to develop short-term capacity development measures in order to redress social inequalities in human capacity development, which will in-turn contribute to enhancement of household capacity to use their skills and asset base to improve their housing and health problems. The study findings have shown that provision of short-term continuing education to micro and small scale business operators and the self-employed in the informal economy sector have proved to be an effective method of skill transfer and development of capacity for the study respondents to reduce their housing and health problems.

It is suggested that the MKUKUTA II should purse a short-term capacity building strategy more vigorously through provision of continuing education to small scale

operators and the self-employed in the informal markets. This training should cover business skills, production techniques and training on legal approaches which will develop their capacities to access credit and to trade within the context of formal markets.

5.5 Recommendations for Areas of Further/Future Research

This section presents recommendations for further areas of future research.

5.5.1 Further Research on Evaluation of Urban Poverty from a Human Capability Approach

The study finds further research is needed in-order to improve our understanding on how to conceptualise and evaluate urban poverty from a capability perspective. The findings that social inequalities in human capability development constraints poor households with means to minimize their housing and health problems serves as basis of future research and studies.

A key area is to conduct further studies to understand how the non-poor in poor urban neigbourhoods acquired their capabilities to improve their housing conditions. The current study has only examined differences between the poor and non-poor. The study recommends future research to concentrate on investigating capacity development processes among the non-poor.

5.5.2 Modeling on Pathways to Capability Development

The issue of developing capabilities of the urban poor is an intriguing one which could be usefully explored by future research. The findings of such research should attempt to model capacity development trends among the urban poor, both in Tanzania and in other LDCs. Such findings would have useful applications to

applied urban welfare analysis, including being able to predict “pathways” out of urban poverty and capability deprivation. This will enable future planning to be able to predict, with more precision, which households are likely to be vulnerable to poverty, and therefore target them with other forms of policy measures.

5.5.3 Validation of Key Variables of Urban Poverty

The background analysis of the current study suggested low human capability development, poor housing conditions and poor health conditions as the reliable predictors of urban poverty. The study recommends more research on the interrelationship of these variables would help us to establish a greater degree of accuracy on this matter.

More broadly, research is also needed to identify if there could be any other intervening variables that affect and/or contribute to the way levels of human capability development, levels of housing and health conditions determine urban poverty. This study recommends large, more randomized controlled studies could be taken to provide more definitive evidence.

5.5.4 How Poverty Affects Urbanisation

Lastly, the study recommends further, collaborative cross-national studies on how poverty conditions affect sustainable urbanizations. It would be interesting to investigate the effects of levels of capability development in cities of developed countries such as in Europe and USA, emerging markets as well as the world’s fastest developing slums. Further research in this field will shed more light on how to manage the observed global trends towards an increasingly urbanizing world.

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APPENDICES

Appendix I: Questionaire

Examining Urban Poverty, Inequalities and Human Capability Development in the Context of Adjustment: The Case of Vingunguti and Buguruni Settlements, Dar-Es-Salaam

A. Identification of Settlement and Area:

1. District: ……..……..
2. Division: …….
3. Ward: ……..
4. Street: ……..…….
5. Area: ……

B. Personal Profile of Head of Household

6. Gender
   (a) Male
   (b) Female

4. Age of Respondent

5. Place of Birth

(Write) …….

6. Place of birth is:
   (a) Rural
   (b) Urban

7. If place of birth is outside Dar-es-Salaam, which year did you come to settle in Dar es Salaam?

8. Highest Level of Education Reached
   (a) Adult education
   (b) Primary education
   (c) Secondary education
   (d) Technical education
   (e) Other (Specify)……...……
   ……
   ……..…….

9. Year of attaining the education

10. Explain the extent to which the education achieved helped you to reduce poverty in the dimension of housing conditions and health during the period of PRS and MKUKUTA implementation (2001 to present)
    ……...……
    ……..……
    ……..……

11. What is your main economic activity?
    ……..……

12. Which year did you start this economic activity?

13. Explain how this (your main economic activity) helped you to reduce accommodation/housing and health problems during the period of PRS and MKUKUTA implementation (2001 to present)?

    ……...……

    ……...……

    ……...……

14. What is your average expenditure per day?
    (a) Below 500/=
    (b) 500 - 1,000/=
    (c) 1,000 – 1,500/=
    (d) 1500 – 2500/=
    (e) 2500-5,000/=
    (f) 5,000 – 10,000/=
    (g) 10,000/= and above

15. What type of productive asset do you own?
    (a) Do not have any
    (b) Shop
    (c) Land
    (d) Other (Specify) ……..……

16. Please explain how you obtained the asset you own?

    ……..

    ……..

17. Explain the use of the productive asset you own to minimise the housing and health problems you have?

    ……

    ……

    ……

    ……

18. In case the asset you own is not used to minimize the problems give reasons?

……..

……..

19. What kind of skill/apprenticeship do you have?

……

……

20. Explain how you use your skills/apprenticeship to minimize your housing and health problems?

……

……

……

……

21. If the skill/apprenticeship you have is not used for such purpose give reasons.

……...……

……..…….

……..……

……..

22. Did you obtain any credit from any micro financial institution?

(a) Yes

(b) No

23. If yes, when was this and what was the amount?

Year: | | | | |

Amount:……..

24. If no, give reasons:

……..……

……..……

25. Explain the kind of diseases your members of household frequently suffer from during the period of PRS and MKUKUTA implementation (2001 to present)?

……..……

……..

26. Which part of income do you spend on meeting health needs?

……..……

……..

27. How many sleep in one room in your household?

28. Assess the condition of rooms your member of family sleep:
    (a) Roof: ……..……
    (b) Floor: ……..……
    (c) Wall: ……..…….

29. Assess the condition of toilet and kitchen you use:
    (a) Roof: ……..……
    (b) Floor: ……..……
    (c) Wall: …….

30. Thank you. This is the end of the interview. Do you have any general comment?

……

……